
AGENCY OVERVIEW**301 ND Department of Health**

Date: 12/23/2014**Time:** 12:35:59**Statutory Authority**

North Dakota Century Code Titles 19, 23, 25 and 61.

Agency Description

- Works closely with the U.S. Environmental Protection Agency (EPA) to safeguard the quality of North Dakota's air, land and water resources through permitting, inspecting, sampling, analytical services and monitoring activities.
- Enables communities to promote healthy behaviors that prevent injury, illness and disease through various state and federal programs.
- Manages programs leading to the detection, diagnosis, analysis, reporting, intervention/referral and follow-up of diseases.
- Provides leadership and oversight for public health and medical emergency preparedness and response efforts in the state.
- Regulates and supports food and lodging establishments, emergency medical services and healthcare facilities including hospitals, home health agencies, nursing facilities, basic care facilities, intermediate care facilities for those with intellectual disabilities, and clinical laboratory services.

Agency Mission Statement

To protect and enhance the health and safety of all North Dakotans and the environment in which we live.

GOALS: To accomplish our mission, the North Dakota Department of Health is committed to:

- Improving the health status of the people of North Dakota.
- Improving access to and delivery of quality health care and wellness services.
- Preserving and improving the quality of the environment.
- Promoting a state of emergency readiness and response.
- Enhancing capabilities to manage challenges such as oil impact, flooding and other emerging activities.
- Achieving strategic outcomes using all available resources.
- Strengthening and sustaining stakeholder engagement and collaboration.

Agency Performance Measures

Agency performance measures are included in each program narrative. They were developed through the Department's strategic planning process. Targets were typically established based on historical data and U.S. averages. Key measures are those addressing tobacco use, obesity, clean air and drinking water, immunization, emergency preparedness, and access to quality health care.

Major Accomplishments

1. Placed 29 health professionals in shortage areas.
2. Achieved accreditation as HealthLead™ for workplace wellness.
3. Enrolled 4,119 people in NDQuits in FY 2014, 266 more than were enrolled in FY 2013.
4. Screened 2,400 women for breast and/or cervical cancer through Women's Way local coordinating units and approved providers.
5. Provided funding to 20 domestic violence/rape crisis agencies to provide crisis intervention, shelter and other services to 913 primary victims of sexual assault, 4,624 new victims of domestic violence and 4,513 children impacted by domestic violence.
6. Provided suicide prevention funding of \$850,000 to schools, tribal organizations, social service agencies and medical agencies.
7. Provided 5,182 sealant applications and 1,817 fluoride varnish applications to students ages four through 18 in about 50 schools statewide. Sealants and fluoride varnish help to protect teeth from tooth decay.
8. Distributed almost 600 cribs and provided safe sleep education to families through the Cribs for Kids Program to help reduce injury and death of infants.
9. Achieved an adolescent vaccination rate for Tdap and meningococcal vaccinations of 95.0 percent and 93.7 percent, respectively.
10. Investigated three major infectious disease outbreaks including hepatitis C (47 cases, to date) syphilis (34 cases, to date) and tuberculosis (27 cases, to date).
11. Activated and staffed Department Operations Center for 15 incidents and provided medical support (staff & supplies) for six community events.

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12. Reduced response time and increased emergency response capacity by placing equipment and supplies in 53 foot emergency response trailers in all eight regions of the state.
13. Distributed \$6.2 million in grants and automated CPR devices to ambulance services and hospitals.
14. Continued to maintain high compliance rates above national levels for all environmental health regulatory programs while responding to increased needs related to the energy industry including 166 citizen complaints relating to environmental quality concerns.
15. Reviewed approximately 1,422 environmental spill reports since July 1, 2012 by conducting field investigations, remediation oversight and enforcement.

Future Critical Issues

- Lack of health care providers in underserved areas of the State.
- The need to provide outreach, training and education to providers and the general public and to implement evidence-based strategies to increase cancer screening rates among all North Dakotans.
- Sufficient funding to develop and implement programs to reduce unintentional injuries, the leading cause of death to North Dakotans ages 1 through 44.
- Sufficient funding to develop and implement programs to reduce and/or respond to intentional injuries due to domestic violence, sexual assault and suicide.
- Availability of public health prevention and health-care programs to address disparate populations.
- Access to oral health services for the low-income and Medicaid populations.
- Lack of health services available to children in child-care and school settings.
- Sustainability of statewide, school-based dental sealant and fluoride varnish programs for children.
- Resources to help North Dakotans make healthy choices to help prevent cancer, heart disease, obesity and Type 2 diabetes.
- Public health workforce shortages.
- Level or reduced funding in most federal grants and increasing inflationary costs, leaving less money for operation of programs and funding of local public health service delivery.
- A multi-system approach is needed to decrease infant mortality related to SUID (Sudden Unexplained Infant Death); the leading cause of infant death for babies ages one month to one year of age in North Dakota.
- Enhanced epidemiology capacity to support Maternal and Child Health and Injury Prevention Program needs.
- The ND WIC Program received federal funding for Electronic Benefit Transfer (EBT) planning and as a result of that contract has a number of ND specific resources including WIC EBT readiness assessment, business capacity, feasibility study and cost estimates for both on-line and off-line technology that will assist the state in the future. ND plans to begin EBT implementation in 2017 (2020 is the mandated deadline) and is spending the next two years updating the WIC management information system to better accommodate EBT.
- Reduced federal funding has compromised our ability to respond to public health and medical emergencies and disasters.
- Some EMS services are struggling to survive due to decreasing volunteerism and funding issues.
- Need for additional staffing to address increased workload in oil country and to comply with increased workload related to completion of critical risk food inspections as recommended in state audit recommendations and by the federal government.
- Continue to Respond to the environmental impacts as a result of the increased activity in the oil impacted counties relating to water, air and wastewater.
- Continue to evaluate permits for increasingly complex and larger projects in areas where the natural capacity of the environment to cleanse itself is becoming limited. Construction of such facilities requires aggressive monitoring and inspection routines to ensure compliance.
- Maintain technical competency of existing and future staff. Employment pressures from private industry, coupled with the hiring away of staff by other state agencies, have resulted in an employee turnover rate higher than the state agency average. In addition, anticipated retirements of key technical and administrative staff will increase the need to hire, train and retain qualified workers.
- Dealing with the new federal environmental regulations.
- Decrease vaccine preventable disease from 40 per 100,000 to 5 per 100,000 population through increased childhood and youth vaccinations.

REQUEST SUMMARY

301 ND Department of Health

Biennium: 2015-2017

Bill#: HB1004

Date: 12/23/2014

Time: 12:35:59

Description	Expenditures 2011-2013 Biennium	Present Budget 2013-2015	Budget Request Change	Requested Budget 2015-2017 Biennium	Optional Budget Request
By Major Program					
Administrative Support	12,248,615	16,910,457	(1,541,319)	15,369,138	4,890,163
Medical Services	13,281,217	17,535,816	623,085	18,158,901	4,710,626
Health Resources	8,048,904	9,838,222	(166,856)	9,671,366	1,108,822
Community Health	55,621,293	68,096,680	(1,275,864)	66,820,816	9,010,061
Environmental Health	42,797,920	50,524,632	(977,593)	49,547,039	11,130,046
Emergency Preparedness and Response	18,085,594	22,664,135	(1,403,652)	21,260,483	11,790,400
Total Major Program	150,083,543	185,569,942	(4,742,199)	180,827,743	42,640,118
By Line Item					
Salaries and Wages	45,733,649	54,757,510	2,461,672	57,219,182	7,733,588
Accrued Leave Payments	0	2,223,289	(2,223,289)	0	0
Operating Expenses	27,884,983	38,395,014	1,293,954	39,688,968	12,091,308
Capital Assets	1,654,993	2,224,288	484,522	2,708,810	1,034,000
Grants	47,719,746	57,610,729	(2,967,139)	54,643,590	21,781,222
Tobacco Prevention & Control	5,485,311	5,544,251	822,942	6,367,193	0
WIC Food Payments	18,097,955	24,659,861	(4,459,861)	20,200,000	0
Contingent Appropriation	717,570	0	0	0	0
Federal Stimulus Funds	2,789,336	155,000	(155,000)	0	0
Total Line Items	150,083,543	185,569,942	(4,742,199)	180,827,743	42,640,118
By Funding Source					
General Fund	32,943,377	46,001,508	(444,705)	45,556,803	39,222,925
Federal Funds	103,226,715	120,309,143	(3,545,520)	116,763,623	1,224,644
Special Funds	13,913,451	19,259,291	(751,974)	18,507,317	2,192,549
Total Funding Source	150,083,543	185,569,942	(4,742,199)	180,827,743	42,640,118
Total FTE	344.00	354.00	0.00	354.00	30.00

REQUEST DETAIL

301 ND Department of Health
Biennium: 2015-2017

Bill#: HB1004

Date: 12/23/2014

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Description	Expenditures 2011-2013 Biennium	Present Budget 2013-2015	Budget Request Change	Requested Budget 2015-2017 Biennium	Optional Budget Request
Salaries and Wages					
Salaries - Permanent	31,858,757	36,061,836	2,359,920	38,421,756	2,770,272
Salaries - Other	0	0	0	0	3,557,440
Temporary Salaries	1,503,209	2,825,710	(655,274)	2,170,436	120,477
Overtime	0	0	248,000	248,000	0
Fringe Benefits	12,371,683	15,869,964	509,026	16,378,990	1,285,399
Total	45,733,649	54,757,510	2,461,672	57,219,182	7,733,588
Salaries and Wages					
General Fund	13,293,673	17,366,719	818,337	18,185,056	6,641,097
Federal Funds	26,945,753	31,060,193	532,538	31,592,731	591,155
Special Funds	5,494,223	6,330,598	1,110,797	7,441,395	501,336
Total	45,733,649	54,757,510	2,461,672	57,219,182	7,733,588
Accrued Leave Payments					
Salaries - Other	0	2,223,289	(2,223,289)	0	0
Total	0	2,223,289	(2,223,289)	0	0
Accrued Leave Payments					
General Fund	0	707,673	(707,673)	0	0
Federal Funds	0	1,515,616	(1,515,616)	0	0
Special Funds	0	0	0	0	0
Total	0	2,223,289	(2,223,289)	0	0
Operating Expenses					
Travel	2,267,215	3,098,190	130,749	3,228,939	330,080
Supplies - IT Software	417,188	646,290	(8,806)	637,484	1,083,186
Supply/Material-Professional	803,131	909,211	(94,899)	814,312	12,350
Food and Clothing	146,445	215,725	(4,015)	211,710	2,700
Bldg, Ground, Maintenance	304,471	209,404	(38,029)	171,375	3,900
Miscellaneous Supplies	15,105	161,631	3,817	165,448	171,360
Office Supplies	255,536	299,728	17,373	317,101	14,395
Postage	442,295	546,774	26,600	573,374	60,390
Printing	503,670	579,642	(12,490)	567,152	89,340
IT Equip Under \$5,000	438,701	343,097	52,503	395,600	59,775
Other Equip Under \$5,000	100,437	59,553	(301)	59,252	7,000
Office Equip & Furn Supplies	125,981	76,691	(31,422)	45,269	43,000
Utilities	546,226	513,143	23,866	537,009	11,968
Insurance	80,610	96,299	2,223	98,522	0

REQUEST DETAIL

301 ND Department of Health
Biennium: 2015-2017

Bill#: HB1004

Date: 12/23/2014

Time: 12:35:59

Description	Expenditures 2011-2013 Biennium	Present Budget 2013-2015	Budget Request Change	Requested Budget 2015-2017 Biennium	Optional Budget Request
Rentals/Leases-Equip & Other	90,041	98,494	(540)	97,954	2,100
Rentals/Leases - Bldg/Land	1,737,156	1,929,048	388,775	2,317,823	172,623
Repairs	896,926	1,140,136	(8,843)	1,131,293	49,880
IT - Data Processing	1,281,812	1,457,753	29,187	1,486,940	402,884
IT - Communications	652,221	656,588	(14,080)	642,508	24,812
IT Contractual Svcs and Rprs	1,787,486	1,954,633	1,530,435	3,485,068	2,830,569
Professional Development	479,637	591,964	(22,802)	569,162	29,200
Operating Fees and Services	662,092	730,367	(172,093)	558,274	40,550
Fees - Professional Services	7,851,583	14,692,738	(706,421)	13,986,317	4,913,393
Medical, Dental and Optical	5,999,018	7,387,915	203,167	7,591,082	1,735,853
Total	27,884,983	38,395,014	1,293,954	39,688,968	12,091,308

Operating Expenses

General Fund	6,505,970	9,728,192	523,810	10,252,002	9,912,206
Federal Funds	18,837,835	24,345,646	704,809	25,050,455	1,304,889
Special Funds	2,541,178	4,321,176	65,335	4,386,511	874,213
Total	27,884,983	38,395,014	1,293,954	39,688,968	12,091,308

Capital Assets

Other Capital Payments	672,345	642,688	(4,748)	637,940	0
Extraordinary Repairs	35,219	343,651	(7,481)	336,170	0
Equipment Over \$5000	668,952	1,219,949	487,251	1,707,200	1,034,000
IT Equip/Sftware Over \$5000	278,477	18,000	9,500	27,500	0
Total	1,654,993	2,224,288	484,522	2,708,810	1,034,000

Capital Assets

General Fund	392,476	791,841	(245,263)	546,578	1,388,400
Federal Funds	1,043,724	1,104,284	559,401	1,663,685	(671,400)
Special Funds	218,793	328,163	170,384	498,547	317,000
Total	1,654,993	2,224,288	484,522	2,708,810	1,034,000

Grants

Grants, Benefits & Claims	46,434,272	56,584,808	(3,117,338)	53,467,470	21,614,222
Transfers Out	1,285,474	1,025,921	150,199	1,176,120	167,000
Total	47,719,746	57,610,729	(2,967,139)	54,643,590	21,781,222

Grants

General Fund	12,164,988	17,407,083	(833,916)	16,573,167	21,281,222
Federal Funds	33,246,010	35,144,646	185,777	35,330,423	0

REQUEST DETAIL

301 ND Department of Health
Biennium: 2015-2017

Bill#: HB1004

Date: 12/23/2014

Time: 12:35:59

Description	Expenditures 2011-2013 Biennium	Present Budget 2013-2015	Budget Request Change	Requested Budget 2015-2017 Biennium	Optional Budget Request
Special Funds	2,308,748	5,059,000	(2,319,000)	2,740,000	500,000
Total	47,719,746	57,610,729	(2,967,139)	54,643,590	21,781,222

Tobacco Prevention & Control

Salaries - Permanent	477,405	612,216	(131,076)	481,140	0
Temporary Salaries	556	0	0	0	0
Fringe Benefits	169,659	265,572	(57,085)	208,487	0
Travel	25,370	43,946	4,352	48,298	0
Supplies - IT Software	4,692	11,132	339	11,471	0
Supply/Material-Professional	17,998	29,677	904	30,581	0
Office Supplies	5,404	6,832	208	7,040	0
Postage	5,867	5,800	237	6,037	0
Printing	38,056	61,265	1,866	63,131	0
IT Equip Under \$5,000	2,418	8,622	(7,497)	1,125	0
Other Equip Under \$5,000	0	4,666	(4,666)	0	0
Office Equip & Furn Supplies	22,732	907	(907)	0	0
Rentals/Leases-Equip & Other	542	759	0	759	0
Rentals/Leases - Bldg/Land	24,834	24,427	283	24,710	0
Repairs	100	100	3	103	0
IT - Data Processing	19,124	14,562	(4,634)	9,928	0
IT - Communications	8,383	10,339	0	10,339	0
IT Contractual Svcs and Rprs	12,039	0	0	0	0
Professional Development	9,766	27,270	830	28,100	0
Operating Fees and Services	499,757	223,962	6,819	230,781	0
Fees - Professional Services	3,487,891	3,332,197	632,966	3,965,163	0
Grants, Benefits & Claims	652,718	860,000	380,000	1,240,000	0
Total	5,485,311	5,544,251	822,942	6,367,193	0

Tobacco Prevention & Control

General Fund	0	0	0	0	0
Federal Funds	2,266,102	2,323,897	602,432	2,926,329	0
Special Funds	3,219,209	3,220,354	220,510	3,440,864	0
Total	5,485,311	5,544,251	822,942	6,367,193	0

WIC Food Payments

Food and Clothing	18,097,955	24,659,861	(4,459,861)	20,200,000	0
Total	18,097,955	24,659,861	(4,459,861)	20,200,000	0

WIC Food Payments

REQUEST DETAIL

301 ND Department of Health
Biennium: 2015-2017

Bill#: HB1004

Date: 12/23/2014

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Description	Expenditures 2011-2013 Biennium	Present Budget 2013-2015	Budget Request Change	Requested Budget 2015-2017 Biennium	Optional Budget Request
General Fund	0	0	0	0	0
Federal Funds	18,097,955	24,659,861	(4,459,861)	20,200,000	0
Special Funds	0	0	0	0	0
Total	18,097,955	24,659,861	(4,459,861)	20,200,000	0

Contingent Appropriation

Travel	1,471	0	0	0	0
Operating Fees and Services	131,559	0	0	0	0
Fees - Professional Services	584,540	0	0	0	0
Total	717,570	0	0	0	0

Contingent Appropriation

General Fund	586,270	0	0	0	0
Federal Funds	0	0	0	0	0
Special Funds	131,300	0	0	0	0
Total	717,570	0	0	0	0

Federal Stimulus Funds

Salaries - Permanent	374,451	0	0	0	0
Temporary Salaries	22,909	0	0	0	0
Fringe Benefits	142,469	0	0	0	0
Travel	5,281	0	0	0	0
Supplies - IT Software	1,087	0	0	0	0
Supply/Material-Professional	6,129	0	0	0	0
Office Supplies	3,871	0	0	0	0
Postage	616	0	0	0	0
Printing	14,202	0	0	0	0
Office Equip & Furn Supplies	488	0	0	0	0
Rentals/Leases-Equip & Other	67	0	0	0	0
Rentals/Leases - Bldg/Land	400	0	0	0	0
IT - Data Processing	50,999	0	0	0	0
IT - Communications	4,047	0	0	0	0
IT Contractual Svcs and Rprs	257,112	130,683	(130,683)	0	0
Professional Development	1,101	0	0	0	0
Operating Fees and Services	50,000	0	0	0	0
Fees - Professional Services	121,446	0	0	0	0
Grants, Benefits & Claims	1,732,661	24,317	(24,317)	0	0
Total	2,789,336	155,000	(155,000)	0	0

REQUEST DETAIL

301 ND Department of Health

Bill#: HB1004

Date: 12/23/2014

Time: 12:35:59

Biennium: 2015-2017

Description	Expenditures 2011-2013 Biennium	Present Budget 2013-2015	Budget Request Change	Requested Budget 2015-2017 Biennium	Optional Budget Request
Federal Stimulus Funds					
General Fund	0	0	0	0	0
Federal Funds	2,789,336	155,000	(155,000)	0	0
Special Funds	0	0	0	0	0
Total	2,789,336	155,000	(155,000)	0	0

Funding Sources

General Fund	32,943,377	46,001,508	(444,705)	45,556,803	39,222,925
Federal Funds	103,226,715	120,309,143	(3,545,520)	116,763,623	1,224,644
Special Funds	13,913,451	19,259,291	(751,974)	18,507,317	2,192,549
Total Funding Sources	150,083,543	185,569,942	(4,742,199)	180,827,743	42,640,118

CHANGE PACKAGE SUMMARY

301 ND Department of Health

Bill#: HB1004

Date: 12/23/2014

Biennium: 2015-2017

Time: 12:35:59

Description	Priority	FTE	General Fund	Federal Funds	Special Funds	Total Funds
A-C 14 Maintain/Incr Immunization Rates of ND Children	2	1.00	2,614,103	176,460	0	2,790,563
A-C 15 Prevention/Response-Infectious Disease	3	0.00	1,566,688	0	0	1,566,688
A-C 16 Forensic Examiner Infrastructure	4	0.00	353,375	0	0	353,375
A-C 17 Newborn Screen Medical Consultant	5	0.00	30,000	0	0	30,000
A-C 39 Cardiac System of Care	6	0.00	601,400	0	0	601,400
A-C 18 Food & Lodging Staffing Increase	7	7.00	1,049,822	0	59,000	1,108,822
A-C 19 Suicide Prevention Program	8	1.00	1,422,043	0	0	1,422,043
A-C 20 Million Hearts Program	9	1.00	1,400,000	139,573	500,000	2,039,573
A-C 21 Loan Repayment Programs	10	0.00	1,617,500	0	0	1,617,500
A-C 23 EMS Database System	12	0.00	480,000	0	0	480,000
A-C 40 Salary Equity Package	13	0.00	437,016	145,672	0	582,688
A-C 24 Health Equity Office Salary Funding	14	0.00	87,975	0	0	87,975
A-C 25 LPHU Workforce Development	15	0.00	275,000	0	0	275,000
A-C 27 Pediatric Obesity Prevention Coordinator	17	1.00	411,747	0	0	411,747
A-C 28 LPHU State Aid Increase	18	0.00	1,960,000	0	0	1,960,000
A-C 30 Rural EMS Grant Assistance	20	0.00	9,600,000	0	0	9,600,000
A-C 32 Diabetes Prevention and Control	22	1.00	0	139,573	0	139,573
A-C 33 Enhanced Western ND Water Quality Monitoring	23	0.00	729,030	0	0	729,030
A-C 34 Domestic Violence/Rape Crisis Program	24	0.00	1,500,000	0	0	1,500,000
A-C 35 Regulation of On-Site Sewage Disposal	25	2.00	385,243	0	0	385,243
A-C 36 CD Prevention - Healthy Communities	26	0.00	850,000	0	0	850,000
A-C 37 State School Nurse Consultant	27	1.00	142,125	0	0	142,125
A-C 38 Women's Way Services	28	0.00	500,000	0	0	500,000
Total Ongoing Optional Changes		15.00	28,013,067	601,278	559,000	29,173,345
Total Optional Budget Changes		30.00	39,222,925	1,224,644	2,192,549	42,640,118

BUDGET CHANGES NARRATIVE

301 ND Department of Health

Bill#: HB1004

Date: 12/23/2014

Time: 12:35:59

Change Group: A	Change Type: A	Change No: 1	Priority:
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Costs to Continue Existing Programs

Administrative Support

Salaries decreased due to turnover in positions and replacements being hired at a lower starting wage. This decrease was offset by the continuation of the second year pay and equity increases. Temporary payroll decreased due to completion of the Vital Records National Association for Public Health Statistics and Information Systems (NAPHSIS) project and the elimination of the Community Transformation Grant.

The majority of the operating lines have decreased due to the removal of the funding for the following programs: Community Transformation Grant (CTG), Bush Foundation Award, NAPHSIS and the Preventive Health (PH) Block grant. Both the NAPHSIS award and the Bush Foundation award were special fund projects that were completed in the 13-15 biennium. The combined special fund reduction in the operating line totaled \$206,880 with a majority of the reduction in the Professional Services account code. The CTG was removed due to the program being discontinued at the federal level. The federal reduction for the CTG grant totaled \$1,234,313 with a majority of the reduction in the Travel, Professional Supplies, Professional Development, Operating Fees and Services and Professional Services account codes. The PH Block Grant decreased by \$150,268 due to a portion of the program being moved to the Community Health Section within the Department's budget. The majority of the reduction for the PH Block grant was in the Professional Services account code. In addition to the above reductions the Leases/Rent of Building account code decreased due to a reduction in federal funding. However, a few account codes did increase due to inflationary increases projected to average approximately 3% each year of the biennium. The other account codes in operating with notable increases were Office Supplies, IT Data Processing, and IT Contractual Services. The increase for Office Supplies is to budget for the increase in paper costs in Vital Records. The increase in IT Data Processing is in Vital Records to finish converting birth and death data from the old mainframe system to EVERS a web based system. Finally, the last notable increase is in the Non ITD Computer Contract line. The increase is for a contract to enhance the Department's Program Reporting System.

Grants increased primarily due to additional funding being awarded to UND to administer the Primary Care program and the loan repayment programs in addition to the increase in the federal funding for the State Loan Repayment Program (SLRP).

Medical Services

The increase in Salaries is due to the continuation of the second year pay and equity increases. Temporary / Overtime and Benefits decreased due to the completion of federal projects and the inability to find qualified temporary staff to fill positions in the immunization program. FTE will be requested in the optional package.

The operating line has increased in part as a result of inflationary increases projected to average approximately 3% each year of the biennium with the exception of the following. Travel has increased in part due to higher airline rates and hotel costs as well as new federal grant funding requiring travel, which includes the HPV, Immunization Sentinel Site Capacity and Immunization Interoperability grants along with the existing Immunization related programs. IT software and Supplies has increased based on the need for computer software on new computers purchases included in the budget. Postage has increased due to the reminder recall notices for the immunization program as well as postage increases in the northwestern region of the state. Our current vendor no longer services that area and using the postal carrier has resulted in increased rates. IT Equipment under \$5,000 has increased based on the recommended replacement cycle for computers in addition to the need to replace printers. IT Data Processing has increased due to project management cost increases associated with the Immunization Interoperability program and Immunization Sentinel program. IT Contractual Services increased due to increased costs for the Immunization registry maintenance, Maven maintenance, and enhancements to the

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current immunization registry. Professional fees have increased due to increased costs for legal fees, as well as increases in professional fee contracts for HPV, Immunization Interoperability, Sentinel Site project management, and Hepatitis and other outbreaks.

Grants decreased due to the federal grant for LPHU Immunization billing coming to a close along with funding being redirected under Professional Fee contracts in the 2015-17 biennium.

Health Resources

The increase in Salaries is due to the continuation of the second year pay and equity increases. The decrease in Temporary / Overtime is due to the removal of the excess authority remaining in the current biennium after a position was added in the Executive Budget (\$140,063) in the 13-15 biennium. This amount is offset by an increased need in overtime as a result of activity in oil impacted counties - \$9,870.

The operating line has increased in part as a result of inflationary increases projected to average approximately 3% each year of the biennium with the exception of the following. Travel has decreased due to travel needs being far less than had been expected in the 13-15 biennium. IT Software and Supplies have increased for Microsoft office software licenses for upcoming replacement computers. IT Equipment under \$5,000 has decreased due to the recommended replacement schedule for computers. Office Equipment under \$5,000 increased for office furniture due to age of the existing furniture. IT Data Processing has decreased due to hosting and programming costs being less than initially anticipated in the 13-15 biennium. IT Contractual Services increased resulting from a decrease of the one-time funding of \$110,000 for the management information system in the 2013-15 biennium offset by an increase of \$130,000 for the maintenance of this system in the 15-17 biennium. Operating Fees and Services have decreased since we will no longer enter into agreements with the ND DOT to provide funding for the purchase of vehicles directly assigned to the Department. Professional Fees have increased due to an increase in administrative hearing and legal fees.

Community Health

The increase in Salaries is due to the realignment of duties and 1.25 FTE from the Tobacco special line item to better address the objectives of the grant funding in the Community Health Section - \$217,000 along with the continuation of the second year pay and equity increases. These increases were partially offset by decreases as a result of turnover in positions and replacements being hired at a lower starting wage. The decrease in Temporary/Overtime is due to federal funding being redirected to professional fees \$121,000 and due to the loss of the Coordinated Chronic Disease, School Health Program, and Early Childhood Comprehensive Systems grants – combined \$407,000. This decrease is offset by increased federal funding of approximately \$390,000 for DHDOSH, Garrett Lee Smith Suicide and Oral Health Mobilization federal grants.

The operating line has increased as a result of inflationary increases projected to average approximately 3% per year of the biennium with the exception of the following: Travel has increased due to travel needs for the HRSA Oral Health and Garrett Lee Smith Suicide federal programs. IT Equipment under \$5,000 has decreased due to the recommended replacement schedule for computers. Other Equipment under \$5,000 has increased due to dental equipment needs for the HRSA Oral Health Workforce Activities grant. Office Equipment under \$5,000 has decreased due to one-time purchases in the 13-15 biennium that are no longer needed in the 15-17 biennium. Lease/ Rental Equipment has increased due to additional copier needs. IT-Data Processing has decreased due to hosting and programming costs being less than initially anticipated in the 13-15 biennium. IT Contractual Services has decreased due to the completion of the redesign and redeployment of the Comprehensive Cancer Control Program and the North Dakota Cancer Coalition website development. Professional Services has increased by approximately \$521,000 as a result of redirected funding from Temporary / Overtime under the HRSA Oral Health grants along with new federal funding from the Garrett Lee Smith Suicide, DHDOSH, and WIC federal grants

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which has been offset by decreased funding due to the loss of federal programs – primarily the Coordinated Chronic and the Cardiovascular Health federal programs. Medical, Dental, and Optical has increased due to supplies needed for the HRSA dental program. The remaining decreases in the operating line are due to loss of federal funding.

The grants line item has increased due to the Million Heart program in Chronic Disease - \$240,000; HRSA Oral Health funding - \$760,000; Garrett Lee Smith Suicide federal program - \$852,000; increased WIC funding to the local WIC sites, increased Preventive Health Community grants and Physical activity grants - \$593,000. These increases have been offset by the decrease in grant payments to Minot State University due to no longer receiving the federal funding Grants to Encourage Arrest – (\$938,000).

The WIC food payments line item has decreased in order to bring the 15-17 biennial request more in line with current spending as caseload has leveled out in the 13-15 biennium.

The Tobacco special line -Salaries and Wages have decreased by 1.25 FTE and \$217,000 as a result of the realignment of duties and FTE to better address the objectives of the grant funding in the Community Health Section. This decrease has been partially offset by the continuation of the second year pay and equity increases. Additionally, this decrease is offset by the following: an increase in Professional Fees for NDQUITS/QuitNet - \$630,000 and an increase in the Grants line for grants to Health Systems for Tobacco Cessation - \$380,000 as a result of increased revenue from carryover in the Community Health Trust Fund.

Environmental Health

Salaries and Benefits increased due to the continuation of the second year pay and equity increases. In addition Temporary /Overtime increased to meet the demand for additional oil field response time and the corresponding lab work.

The operating line has increased in part as a result of inflationary increases projected to average approximately 3% each year of the biennium with the exception of the following. Travel costs increased to accommodate the growing travel due to responses to environmental issues in the oil field. The overall increase in the IT Equipment under \$5000 line is due to the purchase of various scanners to implement electronic document management, expanded use of barcodes, as well as to accommodate 11” x 17” plans. The remainder of the increase is due to cyclical timing for replacement of equipment based on the recommended replacement schedule and current needs. The decrease in Office Equipment under \$5000 is result of office furniture needed in the 13-15 biennium for the newly approved FTE added as a result of the oil impact activity. Building rental costs increased with the addition of the work area in the Gold Seal Building that was formerly occupied by the Public Health Preparedness Division. IT Contractual Services increased for the development of an electronic reporting information system for municipal facilities as well as section wide ongoing maintenance of systems. Overall Professional Fees were reduced, which is predominantly due to a decrease in the requested amount for legal fees for the Title V program. The remaining overall reductions in federal and special funded legal fees for the Section brings the requested 2015-17 biennium more in line with current spending for non-oil impact related legal costs.

The request for capital assets is increasing to allow the spending capacity to replace older equipment should the fee income be adequate to cover the costs.

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The significant decrease in grants is a direct result of decreased federal funding for the Non Point watershed assessments, educational programs, and best practices implementation, as well as the air quality clean diesel programs.

Emergency Preparedness and Response

Salaries decreased due to turnover in positions and replacements being hired at a lower starting wage and the shift of Community Paramedic to temporary salaries. This decrease was offset by the continuation of the second year pay and equity increases. Temporary /Overtime has increased due to adding time for CDL Driver, Network Engineer, IT Support Specialist in addition to the shift from salaries to temporary for the Community Paramedic Coordinator. Also included in this area is increased time for the grants management coordinator and for the warehouse workers along with overtime for the Administrative Assistant. Benefits decreased due to the number of health insurance policies provided to temporary employees decreasing in the 15-17 biennium.

The operating line has increased in part as a result of inflationary increases projected to average approximately 3% each year of the biennium with the exception of the following: Food and Clothing increased due to the planned purchase of uniforms. Both Buildings/Vehicle Maintenance Supplies and Other Equip under \$5,000 decreased due to one-time purchases in the 13-15 biennium that are no longer needed in the 15-17 biennium. Lease/Rentals - Building and Land increased due to relocation of the entire Section to new office space. IT- Data Processing decreased due to an adjustment of HAN user fees on the ITD monthly billing. IT- Contractual decreased due to completion of the Nexus (HPP) contract. Operating Fees and Services decreased as a result of expenditures for the Stroke System of Care being redirected and expended in the grants line item for additional aphasia services in the 15-17 biennium. Professional Services decreased as a portion of the expenditures for the Stroke System of Care are being redirected and expended in the grants line item for additional aphasia services in the 15-17 biennium and the Section is not contracting for the services of four Regional Coordinators to support ambulance services. This function is now being covered by Section staff.

The request for capital assets is increasing to allow for the Department to increase our Medical Cache inventory, which will allow the Department to more adequately respond to emergencies.

Change Group: A	Change Type: A	Change No: 6	Priority:
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Add 2015-17 Bond Payments

Adjustment to add bond payments to the 2015-2017 biennium base budget request

Change Group: A	Change Type: A	Change No: 7	Priority:
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Add 2015-17 Extraordinary Repairs

Adjustment to add extraordinary repairs to the 2015-2017 biennium base budget request

Change Group: A	Change Type: A	Change No: 8	Priority:
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Add 2015-17 Equipment Greater Than \$5000

Adjustment to add equipment > \$5000 to the 2015-2017 biennium base budget request

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Change Group: A	Change Type: A	Change No: 10	Priority:
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EH Attorney Fees

Adjustment to add attorney fees for lawsuits.

Change Group: A	Change Type: A	Change No: 11	Priority:
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Cardiac Care System

Cardiac Care System

NDCC 23-47 required the department to establish and maintain a comprehensive emergency cardiovascular medical system for the state which included an advisory committee, a system plan, system registries and prehospital emergency medical services. To accomplish this during the 2013-15 biennium the department purchased automatic chest compression devices using Helmsley Charitable Trust funding and continued support of the STEMI project which was initiated the previous biennium using Helmsley Charitable Trust funding. The automatic chest compression devices were distributed to the providers through a grant process; this funding was fully expended. Funding needs to continue for temporary salaries, project monitoring, operations, program evaluation, training services, and advisory committee expenses.

Change Group: A	Change Type: B	Change No: 12	Priority:
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WIC EBT UPC

The Division of Nutrition and Physical Activity is replacing their existing WICNet System with the Mountain Plains States Consortium (MPSC) system in the 2015-17 Biennium. The MPSC WIC System is a web-based, smart client application that supports the Women, Infants, and Children (WIC) Program. The EBT technology was a mandatory requirement by the US Department of Agriculture and must be implemented by 2020. Temporary salaries are for collection and data cleanup and for vendor support. IT Equipment under \$5,000 is included for a computer for the temporary employee. IT Contractual Services is for an IT contract with CIBER for the new system. Professional Fees is for quality assurance, service provider, project management, IT support and MIS Upgrade.

Change Group: A	Change Type: C	Change No: 14	Priority: 2
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Maintain/Incr Immunization Rates of ND Children

Maintain and Increase Immunization Rates of North Dakota Children – \$2,790,563 – 1 FTE

Continue funding vaccines for insured children vaccinated at local public health units. \$2.5 million is included in the health department's base general fund budget for vaccine purchase. Funding is also requested for project activities (1 – 6), listed below, plus an additional \$576,853 (activity 7) for purchasing vaccines for insured children seen at local public health units.

The goal of this project is to maintain and increase childhood immunization rates. Project activities include immunization recall of North Dakota children, a school immunization module in the North Dakota Immunization Information System (NDIIS), a study to examine current immunization personal belief exemption policies in North Dakota, an FTE for an NDIIS manager, funding for NDIIS maintenance, and funding for local public health units for immunization activities.

1. Immunization Recall of Children: \$108,150

Funding is requested to notify parents that their children are due or past due for immunizations based on data from the NDIIS. Numerous studies (62) have found immunization reminder/recall to be an effective method of increasing immunization rates.[1] The NDDoH would like to use the NDIIS to send letters to parents of children who are due and/or past due for immunizations. In 2012, the NDDoH received a one-time federal grant (ending August 2015) to conduct immunization

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recall of adolescents statewide. As of July 2014, immunization rates of adolescents have increased by 6.1% for Tdap (tetanus, diphtheria, pertussis) vaccine to 11.6% for chickenpox vaccine. Completion rates for adolescents who started the three-dose human papillomavirus (HPV) series have increased 5.2% for girls and 7.5% for boys. Federal funding for this activity was also requested in the 2015 immunization cooperative agreement. If federal funding is received, state general funding will not be needed.

2. School Immunization Module: \$179,100

During the 2012 – 2013 school year, North Dakota had the fifth worst immunization rate for measles, mumps and rubella (MMR) vaccine in the nation, putting North Dakota children at risk for vaccine preventable disease outbreaks in the school setting.[2] An electronic system is needed to improve compliance with North Dakota childcare, school and college entry requirements and to reduce staff time at schools, local public health units, and the NDDoH to track and report immunization rates. This project is to develop a school immunization tracking and reporting system (module) in NDIIS to assist childcares, schools, colleges and local public health units in determining student compliance with state immunization laws. Children attending childcare, kindergarten through 12th grade, and college in ND must meet entry requirements for specific vaccinations. Parents are required to submit a paper Certificate of Immunization (CIS) to show proof of immunization. Schools are responsible for reviewing the CIS to make sure students are fully immunized and meet state immunization requirements. Schools also have the responsibility to follow-up with, track and furlough students not in compliance with school requirements. The School Module offers a portal into the NDIIS currently used by healthcare providers and mandated for childhood immunizations in North Dakota. An NDIIS School Module would allow authorized schools to link students using data from the longitudinal data system with a school and grade and access immunizations already entered by healthcare providers, rather than spending many hours entering student immunizations in a school specific student information system or tracking students' immunization statuses by hand. The module would notify schools if students are in compliance with state immunization requirements. School staff could print student-specific reports and letters to track required immunizations, and submit the required annual immunization status report required by state law to the NDDoH.

3. Study to Review North Dakota's Personal Belief Immunization Exemption Process: \$100,000

North Dakota's religious, moral, and philosophical exemption policy for immunizations allows children to be exempt from state mandated vaccinations by submitting to the student's school or childcare a CIS with the statement of personal exemption signed by the parent(s) or guardian(s) that they have a personal belief that is opposed to immunizations. (This exemption is only required to be completed upon enrollment and does not need to be revisited by the parent or student in subsequent years.) Due to increasing personal belief exemptions in North Dakota, funding is requested for an external, neutral agency to engage applicable stakeholders and review North Dakota's current law and administrative rules and make recommendations for changes.

4. NDIIS Manager (HSPA III) FTE: \$176,460 (Federal Funds)

An FTE is requested for a position to manage NDIIS activities. A temporary position for the NDIIS was opened twice in 2012 and 2013, and the NDDoH was unable to hire a qualified individual. The FTE will be supported by federal funding.

5. NDIIS Maintenance Costs: \$150,000

The vision of the NDIIS is for all North Dakotans to be included and for all providers in North Dakota to report immunization information, so the system can provide a single data source for statewide immunization partners. The vision to maintain a statewide database of immunization information is an effort to increase immunization rates in order to prevent vaccine-preventable diseases in North Dakota. The NDIIS has been 100% federally funded since the mid-1990s, when it was originally developed. Federal grants have been cut or remain level, but NDIIS maintenance has increased. Noridian Mutual Insurance Company maintains the NDIIS. State law requires all childhood immunizations to be entered into the NDIIS within four weeks of administration. More than 80% of North Dakota adults have at least one immunization in the NDIIS. The NDIIS is electronically connected to 203 provider sites in North Dakota and the North Dakota Health Information Network. The NDIIS is more than just a database of immunizations. NDIIS is capable of conducting reminder/recall, notifying providers when a patient is due or past due for immunizations, vaccine ordering, vaccine inventory management, local public health billing, Vaccines for Children Program accountability, and emergency preparedness and response tracking. NDIIS annual maintenance for 2015 is estimated at \$304,045, increasing a minimum of 3.5% per year. The remaining maintenance will be paid with federal funding. If federal funding is received, state general funding will not be needed.

6. Ensuring Access to Immunizations: \$1,500,000

Funding is requested for local public health units to maintain immunization activities, including community outreach, school vaccination clinics, billing, and ensuring proper storage and handling of vaccines. Funding will be allocated to local public health units using a base plus population formula. Ensuring access to vaccines, especially in western and rural North Dakota, is critical for maintaining and increasing immunization rates. In some counties, private providers do not vaccinate children, so the local public health unit is the sole source of vaccinations. Immunization costs are also supported by federal funding, state aid, and

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insurance billing. Funding is also requested for local public health units to conduct activities to increase immunization rates. Funding for increasing immunization rates will be awarded using a competitive grant process.

7. Vaccines for Insured Children at Local Public Health Units: \$576,853

\$2.5 million is currently in the Department of Health's base budget for vaccine purchase. An additional \$576,853 will be needed for the 2015 – 2017 Biennium. This increase is due to the increasing cost of vaccines and new immunization recommendations. This funding is not needed, if the Legislature decides to no longer fund vaccines for insured children at local public health units.

Below is a breakdown of one-time and continuation expenses:

1. Immunization Recall of Children: July 2015 – June 2016, Continuation Expense
2. School Immunization Module: July 2015 – June 2016, One-time Expense
3. Study to Review North Dakota's Personal Belief Immunization Exemption Process: July 2015 – June 2016, One-time Expense
4. NDIIS Manager FTE: Permanent FTE, Continuation Expense
5. NDIIS Maintenance Costs: July 2015 – June 2016, Continuation Expense
6. Ensuring Access to Immunizations: July 2015 – June 2017, Continuation Expenses
7. Vaccines for Insured Children at Local Public Health Units: July 2015 – June 2017, Continuation Expense

Immunization rates in North Dakota vary by age and vaccine. During the 2012 – 2013 school year, North Dakota had the fifth worst kindergarten immunization rates for measles, mumps and rubella (MMR) vaccine in the nation, putting North Dakota children at risk for vaccine preventable disease outbreaks in the school setting. North Dakota has not yet met Healthy People 2020 objectives for most vaccines recommended for infants, including DTaP (diphtheria, tetanus, pertussis), pneumococcal, hepatitis A, and rotavirus, putting young children at risk for serious diseases and death. North Dakota's vaccination rates for HPV are low, with only 41.1% of girls and 18.4% of boys vaccinated.[3] Less than half of the children in North Dakota receive an annual influenza vaccine.[4] Immunizations are cost effective; for every \$1 spent on vaccine, \$5 is saved in direct costs and \$11 is saved in additional costs to society.[5]

The local public health units estimate spending almost \$900,000 each biennium reviewing school and childcare immunization records.[6] The one-time investment in an NDIIS school module will save this money by automatically determining a child's compliance with state immunization laws. Money will also be saved by private health care providers not having to print paper CIS and schools not having to manually assess compliance with school immunization laws and report to the NDDoH.

Moral and philosophical exemptions continue to increase in North Dakota. Kindergarten exemption rates in 2009 – 2010 were 1.57% and have increased to 2.7% during the 2013 – 2014 school year.[7] In states like North Dakota, where parental signature alone is sufficient to claim an exemption, the incidence of pertussis (whooping cough) was 41 percent higher than in states with more restrictive methods.[8] Furthermore, states that permit exemptions with such ease are associated with higher rates of exemptions in schools[9] and, within states; schools that have higher rates of exemptions may be associated with higher disease rates.[10]

The Community Preventative Services Task Force recommends immunization information systems on the basis of strong evidence (71 published papers) of effectiveness at increasing vaccination rates.[11] There are currently 14,218 active users for the NDIIS. The NDIIS and its data are used in every component of the NDDoH immunization program and by health care providers, pharmacies, local public health units, long term care facilities, and schools. An FTE for an NDIIS Manager is needed to ensure continued success of the NDIIS. The Department of Health has tried to previously hire temporary staff for the NDIIS in 2012 and 2013, but was unsuccessful in getting qualified applicants to apply. The NDIIS Manager will be responsible for coordinating activities between the NDHIN and electronic medical records and the NDIIS, ensuring that the vendor is accountable and completing activities in a timely manner and for facilitating access and ensuring confidentiality of the system.

If it is decided to continue to fund vaccines for insured children seen at local public health units, an additional \$576,853 will be needed for the 2015 – 2017 Biennium, for a total of \$3,076,853 (\$576,853 plus \$2.5 million in NDDoH base general fund budget) for vaccine purchase. This increase is due to the increasing cost of vaccines and new immunization recommendations. It is anticipated that additional vaccines will be recommended in the future and vaccine costs will continue to increase, therefore, the NDDoH will have to request increases in funding for vaccines for local public health units each biennium.

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This request includes funding for health units impacted by oil activities. Private health care providers in Western North Dakota are overwhelmed by the increase in population and are unable to keep up with requests for immunizations, so local public health units have had to increase the number of immunization administered. Health units report an increase in the time spent to find out-of-state immunization records. The request for an NDIIS school module will also assist schools in Western North Dakota with complying with North Dakota school immunization laws by reducing staff time required to be in compliance.

[1] Guide to Community Preventive Services. Increasing appropriate vaccination: client reminder and recall systems. www.thecommunityguide.org/vaccines/universally/clientreminder.html.

[2] Centers for Disease Control and Prevention (CDC) Vaccination Coverage Among Children in Kindergarten — United States, 2012–13 School Year. *MMWR Morb Mortal Wkly Rep*. 2013;62(30):607.

[3] 2013 National Immunization Survey. Teen Vaccination Coverage Data. <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/teen/data/tables-2013.html>.

[4] North Dakota Immunization Information System (NDIIS)

[5] F Zhou *et al*. Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001. *Arch Pediatr Adolesc Med*.159(12):1136-44 (2005).

[6] North Dakota Department of Health. Immunization Funding Needs Assessment. August 2014.

[7] North Dakota Department of Health Annual School Survey

[8] Omer SB, P. W. Nonmedical exemptions to school immunization requirements: Secular trends and association of state policies with pertussis incidence. *JAMA* **296**, 1757–1763 (2006).

[9] Boone v Boozman, 217 F Supp 2d 938 (ED Ark 2002).

[10] Salmon DA, Omer SB, Moulton LH, et al. The role of school policies and implementation procedures in school immunization requirements and nonmedical exemptions. *Am J Public Health*. 2005;95:436–440

[11] Guide to Community Preventive Services. Increasing appropriate vaccination: immunization information systems. www.thecommunityguide.org/vaccines/universally/imminfosystems.html.

Change Group: A	Change Type: C	Change No: 15	Priority: 3
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Prevention/Response-Infectious Disease

Prevention and Response to Infectious Diseases– 1,566,688

1. Catastrophic Fund for Infectious Disease Outbreaks: \$500,000

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The North Dakota Department of Health (NDDoH) Division of Disease Control has been responsible for identifying, responding to, and managing three large infectious disease outbreaks in the past three years. A large tuberculosis outbreak in Grand Forks County, a hepatitis C outbreak in Ward County, and a syphilis outbreak in Sioux County. Funding to respond to current and future outbreaks is requested as a special line item in the NDDoH budget. This estimate is based on the tuberculosis outbreak in Grand Forks County during the 2011 – 2013 biennium which totaled \$478,624.

2. Animal Exposure Module for MAVEN: \$50,000

MAVEN is North Dakota's electronic disease surveillance system. Laboratories and health care providers report infectious diseases to the NDDoH, as mandated by state law, and these diseases are monitored in MAVEN. Animals that test positive for rabies are reported to the NDDoH. The NDDoH Division of Disease Control investigates if there was a human exposure and then works with local authorities to make recommendations for rabies vaccination to prevent the disease in humans. An animal exposure module is needed in MAVEN to facilitate the reporting of positive rabies cases in animals, coordinate rabies exposure investigations between state and local authorities, collect and report rabies data to the CDC and other stakeholders, provide data for analyzing case management, and prevent rabies in humans.

3. Centralized Tuberculosis Medication Distribution: \$50,000

This funding is to establish a contract with a pharmacy to distribute tuberculosis (TB) medications to local public health units for treatment of latent and active cases.

4. Local public health unit tuberculosis management: \$480,403

Funding is requested for local public health units to conduct testing for tuberculosis, treat cases, and coordinate prevention efforts.

5. Local public health unit STD prevention: \$486,285

Funding is requested for local public health units to conduct testing for STDs, interview and counsel cases, notify contacts to cases, and coordinate prevention efforts. The local public health units will be required to bill insurance for STD-related billable services.

Below is a breakdown of one-time and continuation expenses:

1. Catastrophic Fund for Infectious Disease Outbreaks: July 2015 – June 2017, Continuation Expense
2. Animal Exposure Module for MAVEN: July 2015 – June 2016, One-time Expense
3. Centralized TB Medication Distribution: July 2015 – June 2017, Continuation Expense
4. Local public health unit tuberculosis management: July 2015 – June 2017, Continuation Expense
5. Local public health unit STD prevention contracts: July 2015 – June 2017, Continuation Expense

Due to recent outbreaks of infectious diseases occurring in North Dakota and the need for state funding to respond and control these outbreaks, a special line item is needed in the NDDoH general fund budget in the future to respond to ongoing and future outbreaks. Responding to outbreaks often requires a significant amount of staff time, travel, laboratory supplies, medications, and contracts with local public health units for testing and treatment. Funding requested is based on actual costs incurred during the 2011 – 2013 Biennium. The NDDoH Division of Disease Control is monitoring human rabies exposures on paper, making it impossible to use data about these exposures to inform future needs and prevention efforts for rabies. Disease Control currently distributes tuberculosis medications to local public health units. After reviewing North Dakota pharmacy laws and rules, it has been determined that a pharmacist should be responsible for dispensing medications, not the NDDoH or local public health units. Funding is needed to contract with a local pharmacy for this service. The local public health units are responsible for managing the testing and treatment of tuberculosis. The federal grant for tuberculosis does not cover these expenses. Gonorrhea, syphilis, and HIV cases in North Dakota are increasing. The local public health units are responsible for testing clients for STDs, including HIV. Funding is needed for the health units to continue to test for these diseases and to follow-up

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with contacts to cases that test positive for these infectious diseases. Without these services at local public health units, some North Dakotans may not be tested and treated for these infectious diseases and therefore continue to spread these diseases.

This request includes funding for local public health units impacted by oil activity. Local public health units in these areas are responsible for testing residents for STDs, hepatitis, and TB and insuring positive cases and their contacts receive treatment. Cases of HIV, Gonorrhea, and syphilis are increasing statewide, including in Western North Dakota. HIV cases in oil impact counties are increasing greater than the remainder of the state. In 2012, there were 12 cases of HIV in oil impact areas, but as of July 2014, there are already 36 cases of HIV in these same counties, a three-fold increase. In the rest of North Dakota in 2012 there were 31 cases of HIV and in 2014, there have been 42 cases.

Change Group: A	Change Type: C	Change No: 16	Priority: 4
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Forensic Examiner Infrastructure

Forensic Examiner Infrastructure - \$353,375

Continue the current contractual agreement with UND to conduct autopsies serving the counties in eastern North Dakota. The current contract is for \$459,000. The appropriation for the 13-15 biennium was \$480,000. UND has asked for the full \$480,000, which is in the Department's base budget, plus an additional \$250,000 to better address their operating costs. (\$250,000)

Purchase digital X-ray equipment to convert the x-ray services completely to digital format. (\$44,000)

Offset travel costs for training of the coroner or the coroner's designee from each county. (\$29,375)

Provide scholarships to help offset travel costs for five county coroners per year or the coroner's designee to attend the training provided by the Hennepin County Coroner in Minnesota on death investigations. (\$10,000)

Allow the State Forensic Examiner and UND Department of Pathology to review death records electronically and allow these entities to send the electronic record to other medical providers for further review or correction. The Division of Vital Records would work with the Information Technology Department (ITD) to modify the Electronic Vital Event Registration System (EVERS) to accommodate this change. The estimate for those modifications is between \$10,000 and \$20,000. The Division of Vital Records feels that providing such authority to the State Forensic Examiner or his/her designee could be accomplished with a rule change. (\$20,000)

This funding is for continuation expenditures except for the purchase of the digital x-ray equipment.

The contractual agreement is needed to provide the needed forensic services to North Dakota Counties while keeping the workload at the Forensic Examiner's Office at a level recommended by the National Association of Medical Examiners.

Ongoing training is needed to ensure appropriate death scene investigation and appropriate reporting to the county coroner is taking place. In addition this will help increase the number of appropriate referral to either the State Forensic Examiner or UND.

Autopsies from the northwestern part of North Dakota have increased significantly. From the northwestern counties autopsies increased 690% from 2004 through 2013. From the northwest central counties autopsies increased 354% and from the southwest counties 60% from 2004 through 2013. There have been increases in violent deaths, suicides, occupational deaths and motor vehicle deaths.

Change Group: A	Change Type: C	Change No: 17	Priority: 5
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Newborn Screen Medical Consultant

BUDGET CHANGES NARRATIVE**301 ND Department of Health****Bill#: HB1004****Date:** 12/23/2014**Time:** 12:35:59**Newborn Screen Medical Consultant - \$30,000**

The North Dakota Newborn Screening (NBS) Program is requesting a general fund appropriation of \$30,000 to the State Department of Health, Community Health Section, Division of Family Health for the purpose of newborn screening medical consultation during the short term follow-up phase. NBS identifies babies who may have a disorder and alerts health-care providers regarding the possible need for further testing and specialty care. With early diagnosis and treatment, complications may be prevented. Newborn screening was mandated into ND Century Code 25-17-01. This appropriation would be utilized in a professional services contract with a health system(s) which could provide dedicated access to specialty medical providers. This would facilitate timely follow up and intervention for newborn screening cases, some of which could be deemed as medical emergencies and may cause complications. Additional information is listed under the section related to the need for the project.

Continuation expense beginning July 1, 2015.

Newborn screening is more than a series of tests; it requires a closely coordinated system that involves laboratories, geneticists, and other health-care providers working together to protect babies' health. ND Century Code Chapter 25-17-01 states, "the state department of health shall provide, on a statewide basis, a newborn screening system and short term-follow up services for metabolic diseases. The state health department shall also coordinate with or refer individuals to public and private health care service providers for long-term follow-up services for metabolic diseases."

ND screens for over 40 conditions/disorders which include Cystic Fibrosis and Hypothyroidism. The quality of a newborn screening system is highly dependent on the knowledge and expertise of the people involved in follow-up. Some of the conditions are rare; hence primary care providers need assistance with determining appropriate follow-up interventions. Health-care providers need accurate, accessible information about the suspected condition; clear instructions on how to proceed with the confirmatory or repeat testing; and information regarding any required intervention. The medical consultant may need to provide support for the health-care provider in these situations. If some of these conditions are not detected and treated early, the newborn may suffer serious health consequences.

Due to the oil/energy impact in ND, we know that more people have moved to our state. Our population has increased along with our birth rate. This has resulted in an increased number of newborn screening cases which require follow-up and case management.

Change Group: A	Change Type: C	Change No: 18	Priority: 7
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Food & Lodging Staffing Increase

Food and Lodging Staffing Increase - \$1,108,822 – 7 FTE

Additional FTEs are being requested to address not only the increased regulatory work associated with oil activity but also to address recommendations and findings of a recent programmatic audit of the division conducted by the ND State Auditor's Office. Details of the oil impact will be explained on the last page of this request. The programmatic audit noted the division had insufficient staffing levels to operate a food inspection program. The audit recommended the division take the steps necessary to comply with the Food and Drug Administration (FDA) guidelines regarding staffing levels and implementing a risk based inspection system. The division recently re-assigned public health risk categories to all food establishments as mandated by North Dakota Century Code 23-09-11. The food establishments were categorized into one of four risk categories as recommended by the FDA program standards and as recommended in the recent programmatic audit. By re-assigning risk categories on all food establishments, the division can now focus the staffing resources on food operations with the greatest food safety risk. According to the FDA standard, low risk food operations shall be inspected once per year and the highest risk operations shall receive four inspections per year. This will result in an additional need for approximately 1600 more inspections per year.

Another audit finding involved the division not having sufficient staffing at a supervisory level to track, monitor and improve all division functions. One option to address this audit recommendation is to have one of the current FTEs work in the office full-time and have that FTE's current approximately 300 inspections per year turned over to the proposed added field inspection staff. The previously mentioned additional 1600 risk-based inspections plus the 300 turned over from the supervisory office transfer will

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result in needing additional staff to pick up 1900 additional inspections. This same FDA standard states that one full time employee should perform between 280-320 inspections per year.

The recent audit also recommended the division develop improved inspector training procedures and also provide improved oversight of the Memorandums of Understanding (MOUs) set up with the nine local and city health units. To address this audit recommendation, the division intends to have one of the current field inspectors devote half of his time to developing improved and more comprehensive inspector training procedures and manuals. The re-assigning of risk categories as recommended by the FDA and in the recent programmatic audit, devoting another FTE to assist with supervisory responsibilities, having improved inspector training and standardization procedures, in addition to increased oil impact described later, will result in the need for seven new FTEs.

This optional request is a continuation expense.

In order for the division to meet the recommendations of both the FDA standard and the recent programmatic audit, it is important to have additional field inspection staff and additional supervisory support in the office. The strongest need for this project comes from reducing the public health risk to the consuming public. That is why the FDA has developed program standards that were also referenced and recommended by the recent programmatic audit which stated: "Public Health is at risk due to constrained and insufficient inspections being performed on the regulated establishments".

The request is tied mainly to re-assigning of risk categories and the demand for increased number of inspections per year on high risk food establishments as recommended by the FDA and the recent state programmatic audit. However, part of this request is because of the increased number of new establishments in the oil impact areas of the state. Approximately 250 new food and lodging establishments have been licensed and needed inspections the last two years. The majority of these new establishments have started up on the oil impact counties. This has impacted the division in the demands of staff time reviewing submitted plans, conducting pre-operational inspections and conducting routine inspections after licensing. Enforcement action on unlicensed and non-compliant licensed facilities in the oil impact counties has steadily increased over the last couple of years which takes away from staff time needed for routine inspections.

Change Group: A	Change Type: C	Change No: 19	Priority: 8
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Suicide Prevention Program

Suicide Prevention Program - \$1,422,043 – 1 FTE

The North Dakota Department of Health (NDDoH) proposes to utilize the general funds to increase suicide prevention and early intervention for the age 10-24 population with an emphasis on the youth and underserved populations. The NDDoH will accomplish this by 1) increasing suicide prevention education and training across the state to professionals who provide services to the 10-24 year old population 2) developing new materials (including radio, TV and print materials) to reach other disparate populations such as people with special healthcare needs and 3) increasing screening of suicide prevention in the medical facilities across the state and providing physicians referral resources to ensure clients receive appropriate services. It is estimated that this project will reach 88,171 North Dakotans between the ages of 10-24 and that a large portion of the state's population of 723,393 will receive increased suicide prevention messaging as a secondary audience.

This project will require subsequent funding in future biennia.

North Dakota's (ND) suicide rate across all ages is consistently higher than the US suicide rate. Further ND's suicide rate for youth and young adult age 10-24 and American Indian population is consistently higher than the US suicide rate.

According to the Youth Risk Behavioral Survey (YRBS) that was conducted in ND with grades 9-12 in 2011 and 2013, all four indicators of suicidal ideation and attempt increased. When looking at the results from the ND students in grades 7-8 the results from 2011 to 2013 are not quite as linear but still show an overall increase of suicide ideation and suicide attempts.

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The problem of suicide continues into our institutions of higher education. From the period of 2008-2012, 86 of the suicides were between the ages of 18-24 which typically covers the period of time people are in institutions of higher education. This makes up 15.7% of the suicides in ND during this time period (ND Vital Records).

ND has a population of 54,782 veterans (US Census 2012). From a time frame of 2008-2012 18.8% of the suicides in ND had reportedly served in some branch of the armed services.

This project originated from a grant that was written for youth suicide prevention, and if awarded would be funded from the Substance Abuse Mental Health Services Administration (SAMHSA) Garrett Lee Smith (GLS) funds. If awarded funding, costs other than the new full time employee (FTE) would be redacted from this budget as federal funds would cover the costs of this project.

It is undetermined if the oil impact in ND is affecting the occurrence of suicide in ND. NDDoH recently began looking at the suicides of both residents and non-residents in ND, in the past had just looked at the resident data. Both resident and non-resident suicides have increased over the last several years. While suicide appears to have increased statewide, there are areas of concern that are in the northwestern part of the state. Recently due to the increases in suicides, it has also been requested to begin looking at occupations of those deceased to offer occupation related interventions, it appears that additional programming would benefit in occupational areas that may work in energy related fields. Further data will have to be gathered before being able to make a definitive statement, however we know that suicide is always multi-faceted and there is no one single cause for a suicide.

Change Group: A	Change Type: C	Change No: 20	Priority: 9
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Million Hearts Program

Million Hearts Program - \$2,039,573 – 1 FTE

Americans overestimate their own health, and this puts them at greater risk for heart disease and other serious illness. Prevention is important to changing this dynamic. ND employers and healthcare providers can help. That's why private, public and healthcare providers from some of our state's corporate, government and health organizations are coming together to propose significant investment to address 2 of the state's leading chronic disease risk factors, high blood pressure and smoking, to create a workplace, agency and community culture in which healthy choices are the default choices. Together, they will work leading by example to help meet a goal of improving the cardiovascular health of all Americans 20 percent by 2020.

\$800,000 Million Heart®s B- Grant

- Diagnosed with hypertension but it is not controlled: Assists in implementing a large-scale primary care systems change. The grantee(s) must address policies or system change(s) utilizing evidence or practice-based strategies. This includes development and/or enhancement to monitor higher risk patients more closely leading to a decrease in complications associated with high blood pressure (bp). Utilization of primary care.
- Undiagnosed (unaware that they have hypertension): Focus on the undiagnosed patients, including referring those that may be at risk to primary care. Utilization of occupational medicine and worksite wellness.

\$200,000 Team Based Care

- Through the use of health extenders in the community, including pharmacists, eye doctors, chiropractors and community paramedics, the monitoring of patients with high bp and/or promoting self-management of high bp among patients. This will be completed through the health extenders in the community.

\$500,000 Million Hearts® S-Grants: Smoking Cessation

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- Focus on establishing “Cessation Centers” within an existing tertiary hospitals and corresponding healthcare systems. This portion could qualify for funding from the Tobacco Prevention and Control Center.

*\$400,000 Health Communication Interventions**\$139,578 - FTE*

Together through the *HND* Statewide Vision and Strategy core leadership and strategic partners such as NDHCR, AHA, and many others, these stakeholders are leading by example to meaningfully engage their collective employees, providers and ND communities to improve health by making simple behavior changes that produce significant results. The proposed initiative brought forward by these leaders will drive a culture of health by collaborating on best practices and measurable new strategies for employee, healthcare and community engagement. Targeted impact areas are within the Million Hearts® (MH) ABCs initiatives (**A**spirin when appropriate, **B**lood pressure control, **C**holesterol management, and **S**moking cessation). Proposed MH strategies address hypertension and expanded smoking cessation support. Core leadership has collectively pledged to: 1) Serve as stakeholder partners in leading efforts. 2) Disseminate and support evidence-based outcomes on the science of health in the workplace among employers and employees. 3) Incorporate innovative technologies that help employees build, maintain and monitor healthy lifestyle habits as they relate to hypertension and cessation control. 4) Promote evidence-based common standard for health programs. 5) Recognize companies that create a culture of health and improved health outcomes for their workforce. 6) Amplify a clear call to action for other state leaders to join us and take action in their own companies and communities.

Heart disease and stroke are the 1st and 4th leading causes of death in the US. Heart disease is responsible for 1 of every 4 deaths in the country. In ND, stroke is currently the third leading cause of death, and statewide stroke registry data is reflecting occurrence at a younger age level and when our workforce is at its most productive age level. Seventy percent of strokes captured in the stroke registry have hypertension recorded as a key risk factor. MediQhome (MQP) reports that there are 154,022 North Dakotans being monitored or treated for high bp, and that only 75% are considered controlling their bp.

The suggested platform for *HND* impact is the Million Hearts® initiative, a national initiative that has set an ambitious goal to prevent 1 million heart attacks and strokes by 2017. The impact will be even greater over time. MH focuses on the prevention of heart attacks and strokes through achieving excellence in the ABCS (**A**spirin when appropriate, **B**lood pressure control, **C**holesterol management, and **S**moking cessation).

MH emphasizes the use of the following priority strategies: team-based care, health information technology, medication adherence, clinical-community linkages, and alignment of payment with outcomes in innovative models of care and sodium reduction.

MH brings together existing efforts and new programs to improve health across communities and help Americans live longer, healthier, more productive lives. The CDC and Centers for Medicare and Medicaid Services are the co-leaders of Million Hearts working alongside other federal agencies. Key private-sector partners include the American Heart Association and YMCA, among many others.

Further guidance is now available for the “s” of the ABCs by the CDC-Office on Smoking and Health. The Cessation Intervention component guiding principles includes system changes within health care organizations complement interventions in state and community settings by institutionalizing sustainable approaches that support individual cessation behavior change. Three major goals are outlined for the comprehensive state tobacco control program cessation activities, in which the Tobacco Prevention and Control Program is the lead, should focus on: Promoting health systems change; expanding insurance coverage and utilization of proven cessation treatments; and supporting state quitline capacity.

Effective tobacco cessation interventions advance the goals of national and state health care reform efforts to improve health care, to improve health, and to reduce health care costs – similar to the outcomes sought within the hypertension initiative. Health systems change involves institutionalizing cessation interventions in health care systems and integrating these interventions into routine clinical care. This increases the likelihood that health care providers will consistently screen patients for tobacco use and hypertension, and intervene with patients, thus increasing hypertension control and cessation - making evidence-based treatment the standard of care. When a health system seeks to intervene with every patient at every visit, it can substantially and rapidly increase in control of these two leading risk factors.

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The tobacco program currently offers technical assistance and support to help worksites, health care organizations and providers measure the implementation of health systems changes through heart and stroke systems of care, in addition to the Million Hearts®-S program in which all tertiary hospitals across the state are involved. Within Million Hearts®-S, this involves providing technical assistance to health care organizations in implementing health systems changes that institutionalize tobacco use screening and intervention, including referrals to NDQuits. Studies of academic detailing initiatives have found that they have the potential to increase: use of the ask, advise, and refer (AAR) frequency of tobacco cessation counseling; appropriate use of cessation medications; and fax referrals to NDQuits.

Efforts to promote community and health systems change is demanding and time-intensive, requiring a sophisticated understanding of hypertension and tobacco cessation, in addition to health care systems and sustained relationship-building with health care organizations.

Through this MH initiative, the focus within the ABCS will be **B**- Bp Control and **S**-Smoking Cessation. The **A**-Aspirin when appropriate and **C**-Cholesterol management may be addressed in the future.

July 1, 2015-June 30, 2017. It is anticipated that the appropriation continues into subsequent bienniums to support these efforts.

The Statewide Vision and Strategy committee identified the development of a multi-year public/private hypertension initiative as a key wellness and prevention strategy. The initiative aims to increase the percentage of North Dakotans who have their bp under control through both greater awareness and control of hypertension, the state's leading chronic disease risk factor. The MQP estimates that at least 154,022 ND adults are being monitored or treated for this condition. The short-term objectives include: identify and engage partners and organizational support and coordination; develop a work plan; establish data measurement source(s) by which to measure impact; establish baseline and goals; determine resources needed and sources from which to seek support; and identify and engage target communities (target communities may include faith-based groups, worksites, schools and other organizations that function as communities).

The overall outcome is to increase control of hypertension through health system interventions. Increasing the number of healthcare systems implementing quality improvement processes will lead to better care resulting in an increased control of hypertension. Increasing the use of team-based care will allow patients to have a more comprehensive care plan that will help them control their hypertension, reducing the number of complications associated with hypertension. Utilizing a team-based care approach will also encourage medical professionals to provide optimum care and help patients manage their own care to achieve control of their health conditions and diseases.

Another overall outcome is to link community and clinical services leading to an increase in the number of people who have access to a lifestyle change program. This, in turn, will result in an increased number of people who have increased control of hypertension. Increasing the use of healthcare extenders in community settings will provide for increased access to programs offering self or disease management programs. These linkages will increase the number of people with controlled bp.

The increased partnership and utilization of healthcare extenders in the community to support self-management of high bp by reaching out to existing programs will continue. There are several programs being conducted by pharmacists or nurses that are only offered to beneficiaries of specific insurance providers. This program will work with the coordinators of these existing programs to identify opportunities to expand the beneficiaries of other insurers as well as identify expansion of the programs to more sites across ND.

This request is not a result of oil impact activity.

Change Group: A	Change Type: C	Change No: 21	Priority: 10
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Loan Repayment Programs

Loan Repayment Programs - \$1,617,500

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The North Dakota Department of Health (NDDoH) currently administers loan repayment programs for physicians, nurse practitioners, physician assistants, and dentists. The NDDoH is also proposing the addition of a loan repayment program for mental/behavioral health care providers.

North Dakota Century Code Chapter 43-17.2 authorizes loan repayment for qualified physicians who agree to practice in areas with defined health professional medical need in communities of not more than fifteen thousand persons for the purpose of increasing the number of providers serving in these areas. Each recipient is eligible to receive up to \$90,000 to help repay education loans and is required to serve in the community for two years. Currently, communities provide a 1:1 match for this award.

The NDDoH is proposing to increase the funding in this program to make six awards to support physicians that practice in communities of 15,000 or less and eliminate the required 1:1 community match required. If not all six slots are filled with providers practicing in communities with populations less than 15,000, awards can be made to providers practicing in communities greater than 15,000 but would require the 1:1 community match. - **\$472,500 (NDCC change for match requirement)**

North Dakota Century Code Chapter 43-12.2 authorizes loan repayment for nurse practitioners, physician assistants, and certified nurse midwives who agree to practice in areas with defined health professional medical need in communities of not more than fifteen thousand persons for the purpose of increasing the number of providers serving in these areas. Each recipient is eligible to receive up to \$30,000 to help repay education loans and is required to serve in the community for two years. Currently, communities provide a 1:1 match for this award.

The NDDoH is proposing to increase the funding in this program to make six awards to support nurse practitioners, physician assistants, and certified nurse midwives that practice in communities of 15,000 or less and eliminate the required 1:1 community match required. If not all six slots are filled with providers practicing in communities with populations less than 15,000, awards can be made to providers practicing in communities greater than 15,000 but would require the 1:1 community match. The amount of the award would be increased from \$30,000 to \$60,000 for a 2-year service commitment. - **\$382,500 (NDCC change for match requirement and to increase the amount provided to each recipient)**

Two separate programs are currently available for dentists practicing in North Dakota.

1) North Dakota Century Code Chapter 43-28.1-01 authorizes loan repayment for dentists to serve in communities with a defined need for the services of a dentists. Community selection criteria is based on the size of community, number of dentists practicing in the community/area, access to a dentist, the mix of dental specialties in the community/area and the support of a dentist for that area. Current law allows funding for three dentists each year. The recipient can receive up to \$80,000 in loan repayment for a four-year commitment.

The NDDoH proposes increasing the dental loan repayment awards to \$90,000 and increase the number of awards to five. - **\$157,500 (NDCC changed needed to allow funding for additional dentists per year and increase the amount provided to each recipient)**

2) North Dakota Century Code Chapter 43-28.1-01.1 authorizes loan repayment for dentists who practice in a public health setting or nonprofit dental clinic that uses a sliding fee schedule to bill patients. Three dentists during the first year of each biennium can be selected into this program and receive \$60,000 for a three-year service commitment.

The NDDoH proposes increasing the public health nonprofit loan repayment awards to \$90,000 and increasing the number of awards to four. - **\$180,000 (NDCC changed needed to allow funding for additional dentists per year and increase the amount provided to each recipient)**

New Practices – Grants: North Dakota Century Code Chapter 43-28.1-09 provided a grant for the purpose of establishing a dental practice in a city which has a population that does not exceed 7,500.

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As this program is not currently being utilized, the NDDoH proposes to increase the overall grant from \$25,000 to \$100,000 over 5 years to support a dentist who graduated from an accredited dental school within the previous five years and is licensed to practice in North Dakota. A dentist receiving these funds must commit to practice in the community for five years. The NDDoH proposes elimination of the match requirement. - **\$20,000 (NDCC change for match requirement and to increase the amount provided to recipient)**

The NDDoH proposes the development of a new loan repayment program for mental/behavioral health providers to include licensed social workers, licensed professional counselors, licensed addiction counselors, psychiatric nurse practitioners, licensed practical nurse, and registered nurses. Funding would support one clinical psychologist and a total of four awards would be available for providers from any of the following disciplines: social workers, addiction counselors, professional counselors, psychiatric nurse practitioners, licensed practical nurses, and registered nurses. Awards are prioritized based on community size. If not all six slots are filled with providers practicing in communities with populations less than 15,000, awards can be made to providers practicing in communities greater than 15,000. The psychologist would be eligible to receive up to \$90,000 in loan repayment; the social workers, addiction counselors, professional counselors, psychiatric nurse practitioners, licensed practical nurses, and registered nurses are eligible to receive up to \$60,000 in loan repayment. - **\$495,000 (NDCC needed to establish this discipline)**

Of the \$1,707,500 project costs, \$90,000 has been included in the base budget.

The changes proposed will continue into future biennia.

The NDDoH Office of Primary Care participated in a Multi-State/NHSC Retention Collaborative to analyze factors associated with retention of health care providers. Results from the findings of the first year retention survey, November 5, 2012, found that loan repayment programs are generally a good public investment with a continued payoff beyond the years of program support. Long term retention for clinicians who are supported through loan repayment programs can multiply the value of the public investment. This data as well as data from other studies show that most obligated clinicians remain in their service sites for several years after their service terms are completed.

One way to measure need for health care providers is through the Health Professional Shortage Area (HPSA) designation which is a federal designation determined by the Health and Human Services Secretary. Ninety-two percent of the state is designated as a Primary Care Health Professional Shortage, 94% is designated for mental health, and 33% for oral health.

The NDDoH primary care office conducts health provider demand assessment to determine the primary care needs across the state. Fifty-seven (57) openings for physicians in family medicine, internal medicine, obstetrics, and pediatrics in rural areas of the state, were identified and nineteen openings for nurse practitioners or physician assistants were recorded. Vacancies for mental health and oral health are best indicated by the degree of shortage related to the HPSA maps. No formal surveys are regularly conducted for these disciplines but 13 openings for psychiatry, psychology, and psychiatric nurse specialist were included in the last demand survey.

A report was prepared for the ND Legislature by Schulte Consulting, LLC on *Behavioral Health Planning: Final Report*, July 22, 2014, that cited several issues with the ND mental health system including expanding the workforce. One way the NDDoH can assist is by creating a flexible loan repayment program for mental/behavioral health providers.

Loan repayment is an incentive that has proven to be helpful in recruiting health care providers to serve in rural and underserved areas of the state. A study of our physician participants from 1993-2010 reveals that twenty-nine physicians have received loan repayment. The majority have been graduates of UNDSMHS. Of the 20 physicians that have completed their program obligation 83% (19/23) have been retained (defined as providers completing their service obligation and remaining at the same practice site one year following completion of the loan repayment program). Of those that have completed their obligations, all have remained in North Dakota providing documentation that supports the success of the loan repayment program.

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Of the 697 primary care physicians reported in 2013, 29.4% (205/697) were located in rural North Dakota. Approximately 38% of the nurse practitioners and 36% of the physician assistants practice in rural areas of the state. For oral health, the majority of dentists (67%) are practicing in the four most populated cities in North Dakota and 42 of the 53 North Dakota counties (79%) have six or fewer practicing dentists. The data also indicates that 17 North Dakota counties (32%), equating to more than 50,000 people, were lacking a dental provider residing in that county (NDSBDE, 2013). Ninety-four percent of the state is federally designated as a Mental Health Professional Shortage Area. Developing a new program for mental/behavioral health providers is critical for recruiting providers in areas where services are lacking.

The request is, in part, due to the activity in the oil impacted area. The population surge in workers coming to the oil fields has resulted in an imbalance between the demand for health care and the supply of health care providers. While some areas have a sufficient number of physicians, other areas have shortages which will affect the health needs of the population. This has put added pressure on our health care facilities in trying to meet the health care needs of the growing population. Of the 14 applications approved by the State Health Council in April 2014, 10 applications were approved for providers serving in western North Dakota.

Change Group: A	Change Type: C	Change No: 23	Priority: 12
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EMS Database System

EMS Database System - \$480,000

DEMST requests an optional package for the replacement of the current database system within the Division.

The current ambulance run database system is outdated and the support for the system lacks company support. The purchase of the system dates back to 2004 and there may be an upgrade to the database available next year.

With the advances in technology and medical equipment we can no longer tolerate proprietary systems that aid in the establishment of segregated information technology. It is essential that whatever technology systems we put in place must work together in order to achieve the synergy of a true system, not exclusive systems that isolate themselves from interconnectivity of multiple components. This destroys the possibility allowing for multiple opportunities for these components to form an integrated technology platform.

The components of this platform include but are not limited to run status of ambulances, an emergency patient care record that can be uploaded to the run reporting requirements of the state, application for Emergency Preparedness and Response to include patient and bed tracking, a database which can aid in the quality improvement of emergency healthcare, and a common platform by which services can automatically transmit various data points for evaluation and physician access to quality improvement data.

The new system would be a one-time cost of 448,000 and ongoing costs of \$32,000 for maintenance.

A dire need exists to upgrade our system into a more modern system not only for ease of use but also for accommodation of new technology in the EMS arena. With current economic activity that is occurring within the State of North Dakota the demand on the Division has increased dramatically. This system will allow the Department to provide these services that the citizens of North Dakota demand and deserve without increasing costs of staff to the Department. Federally we are also required to submit certain data points to the National EMS Information Systems database and this product will accomplish these mandates.

Below are some issues with the current system:

- Inability to share patient information with the hospitals easily. It is a manual process where a person can view and print the information.
- Inability to electronically transmit and receive information with a hospital electronic health record.

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- Inability to generate Quality Improvement reports for individual EMS agencies
- Inability to create ad hoc reports with ease

Change Group: A	Change Type: C	Change No: 24	Priority: 14
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Health Equity Office Salary Funding

Health Equity Office Salary Funding - \$87,975

Health disparities efforts began in the 1990s to coincide with the national emphasis on health. The movement for healthier North Dakota began with the Department of Health taking steps that recognized and created strategies to provide awareness of inequities in health and access. Former Governor John Hoeven in 2002 included healthy North Dakota in his plans. This declaration helped certain groups to take the lead to address health disparities in the state. The health disparities group defined health disparities in North Dakota as inequalities in health status, utilization or access due to structural, financial, personal or cultural barriers.

In 2007 the state legislature created the Office for the Elimination of Health Disparities, (name changed to Health Equity Office) but did not provide funding for the office. Instead, federal funding was received that created an office of health disparities. Federal funding was received for six years that employed staff who initiated health equity by working with the groups who lacked health resources and needed health services. The Health Equity Office currently does not receive federal funding for its activities. The office is funded through the Department of Health funds that provide funding for the basic infrastructure for Health Equity. The Health Equity Office continues to play a key role in linking and coordinating programs and plans among North Dakota's tribal nations, who have the highest and poorest health disparities in the state. The Health Equity Director has been active in Healthy North Dakota Coordinating Committee activities and will continue to bring awareness and health resources to the tribal nations. However, in working with the tribal nations it has been found that a blanket one-size-fits-all policy or plan does not work for every tribal nation; each has its own tribal members, culture and priorities that must be considered on an individual basis. The large disparities that exist amongst people in our state, in particular the large differences between healthy status in American Indians and Whites needs time, attention and access to resources that can be facilitated through the Health Equity Office.

The funding is for ongoing funding.

Health disparities in the state are significant and exist across the life span. American Indians make up little over 5 percent of the population in the state, but account for 51 percent of Infant Mortality (IMR) in the state. In 2009 the ND IMR was 5.4 per 1,000 live births for the general population, but it was 16.7 percent for American Indians. Similarly, the mortality rate for children ages 15-18 years due to unintentional injury in 2008 was 1,327 per 100,000 people for American Indians, but it was only 495 for the White population. The mortality rate for ages 0-44 years in the state was 282.1 per 100,000 for American Indians, but only 82.4 for the White population, which is alarming.

The rate of diabetes among American Indian adults (11.3 percent) is radically higher than that of whites (7.6 percent). Although the prevalence of diabetes is nearly double for American Indians, the mortality rate from diabetes is nearly six times greater (144.2 per 100,000 for American Indians versus 25.4 for Whites). American Indians living in the state experience death due to cardiovascular disease at twice the rate of death for whites; strokes mortality is also higher for American Indians than for Whites.

Fort Berthold Indian reservation has been greatly impacted by oil activity, therefore the Health Equity Office will continue to work with the tribe to establish a local public health unit on the reservation that will provide relief for the tribe in dealing with new populations and other health developments caused by increased activities on the reservation. So this request is a result of oil activity on the reservation.

Change Group: A	Change Type: C	Change No: 25	Priority: 15
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LPHU Workforce Development

LPHU Workforce Development - \$275,000

BUDGET CHANGES NARRATIVE**301 ND Department of Health****Bill#: HB1004****Date:** 12/23/2014**Time:** 12:35:59

The Office of Local Public Health requests \$275,000 per biennium to support local public health workforce training and educational needs to enhance the delivery of the Essential Public Health Services in our ever changing public health environment.

The project period is 2015-2017 and is a continuation expense.

Local public health units (LPHUs) are the foundation of North Dakota's public health system and the lead organizations providing community based programs and services that assure and protect the health of our citizens. A well-prepared and competent local public health workforce is the foundation to a healthy community. Training and educational opportunities are vital to nurture and sustain a workforce that is capable of improving health outcomes and effectively delivering the Essential Public Health Services.

Today, our state faces a widening gap between challenges to improve the health of North Dakotans and the capacity of the public health workforce to meet those challenges. In addition to other dynamics, our state's growth in population and diversity and increased challenges in protecting and preserving the environment and the population's health require an increasingly skilled body of public health professionals.

The Midwest Center for Lifelong Learning in Public Health conducted a needs assessment of the North Dakota local public health workforce to determine the need for and interest in succession and diversity planning training among local public health units; established baseline data about the diversity of the public health workforce; and identified and prioritized other training needs and interests. The analysts indicated a need for training around discipline-specific education for staff and technical public health skills.

The North Dakota Master of Public Health Program has created a comprehensive set of educational training opportunities for public health practitioners in the state. The opportunities focus on competencies in core discipline areas of biostatistics, epidemiology, environmental health, social and behavioral sciences, and health services administration in addition to competencies in cross-cutting areas including leadership, communication and informatics, diversity and culture, program planning, and systems thinking. Courses are also offered through distance learning which have made these opportunities accessible to working public health professionals throughout the state. However, the cost for continuing education opportunities is a large barrier.

LPH funding sources are generally from local government, state government and federal pass-through funds. The majority of budget consists of federal pass-through funds and local government funding. The federal pass-through funds are categorical funding and typically not available for workforce development whereas, local government funding is a flexible, non-categorical funding source but is needed to respond to community health needs (which also limits availability of funds to be used for workforce development). The North Dakota MPH Program does offer many specialized certification programs including environmental health, health care policy, American Indian health studies, etc. that will address the training needs identified by local public health. The cost for a certificate program is about \$11,160 per student.

LPHUs employ about 300 professional FTEs that potentially could take advantage of continuing and advanced education opportunities. About 6 % of the professionals are environmental health practitioners that would benefit from the environmental health certificate program. A scholarship or tuition reimbursement program and policy needs to be developed. Financial support or tuition reimbursement for a predetermined number of credits or total amount per student is needed to enhance the competencies of the LPH workforce. \$275,000 for the biennium is requested to support about 25 local public health professionals in their workforce training needs.

Change Group: A	Change Type: C	Change No: 27	Priority: 17
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Pediatric Obesity Prevention Coordinator

Pediatric Obesity Prevention Coordinator - \$411,747 – 1 FTE

The Nutrition and Physical Activity Division is requesting a position and funds to establish a Pediatric Obesity Prevention Coordinator. ND is rated 16th in the nation, up from 25th in the nation, in its percentage of obese and overweight residents. The obesity rate for children, while leveling off a bit the past year, has reached dramatic levels.

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For the first time in our history, the children born today may not experience longer lifespans than their parents, and one in three children born in 2000 are anticipated to develop diabetes at some point in their lives if we continue on as we are as a society.

Obesity prevention needs to happen at the stage when children are still growing, before negative habits are set and metabolic pathways are altered, and before negative and social health consequences begin. With the focus on youth we have the ability to affect long term changes resulting in healthier and happier lives for ND children with the likelihood that they will grow up to be healthy and productive adults that make up our future workforce. The Pediatric Obesity prevention Coordinator will provide assistance to health care providers, public health, communities, parks and recreations, child care facilities and schools to help to change those places that touch children's lives every day to positively impact health the state's youngest residents. .

Prevention measures such as healthy environments and control of risk factors are important steps to improve lives, reduce disability and lower healthcare costs. The coordinator will work with communities to encourage partners to help provide environments where children can maintain a healthy weight; engage in regular exercise, eat well and participate in regular health screenings. Technical assistance and support to communities will be provided by the Pediatric Obesity Prevention Coordinator drawing on principles from the social ecological model, with interventions for individuals and environments, and from best practices, promising practices and practices proven to yield positive results. It is proven that the one thing to stop and even reduce the growing rates of obesity are multi-pronged coordinated efforts. There is not currently a position at the state level focused on this important aspect in the prevention of not only obesity, but also the prevention of related chronic diseases of diabetes, heart disease, asthma and cancer.

Continued: For FY15-16 \$193,520 and FY16-17 \$218,227 and plan to continue program in future

- According to CDC paper, childhood obesity can have a harmful effect on the body in a variety of ways. Obese children are more likely to have—
 - High blood pressure and high cholesterol, which are risk factors for cardiovascular disease (CVD). In one study, 70% of obese children had at least one CVD risk factor, and 39% had two or more.²
 - Increased risk of impaired glucose tolerance, insulin resistance and type 2 diabetes.
 - Breathing problems, such as sleep apnea, and asthma.
 - Joint problems and musculoskeletal discomfort.
 - Fatty liver disease, gallstones, and gastro-esophageal reflux (i.e., heartburn).
 - Obese children and adolescents have a greater risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood.
- According to CDC, later on obese children are more likely to become obese adults. Adult obesity is associated with a number of serious health conditions including heart disease, diabetes, and some cancers. If children are overweight, obesity in adulthood is likely to be more severe.
- Because of the increasing rates of obesity, unhealthy eating habits, and physical inactivity, we may see the first generation that will be less healthy and have a shorter life expectancy than their parents.
- Locally, in recent public health round tables, six of the 12 local North Dakota Public Health sites involved in the discussions identified obesity as one of their top 10 issues and another 4 identified chronic disease in their community concerns.

This request is not a result of oil impact activity. This is a long time trend across the state and across the nation.

Change Group: A	Change Type: C	Change No: 28	Priority: 18
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LPHU State Aid Increase

LPHU State Aid Increase - \$1,960,000

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The Office of Local Public Health requests \$1,900,000 per biennium to support local public health operations to specifically enhance the delivery of two core public health activities; protect against environmental hazards and prevent injuries.

The project time period is 2015-2017 and it is a continuation expense.

Local public health units (LPHUs) are the foundation of North Dakota's public health system and the lead organizations providing community based programs and services that assure and protect the health of our citizens. Local health departments serve as the primary organizing and mobilizing forces for public health practice in most communities and are critical to protecting the health of the community. While the state department generally maintains responsibility for implementing public health policies and programs, they do so largely through the relationships with local health departments. Therefore, a close working relationship between the state and local health departments is vital for an effective public health system. The state department relies on a strong local infrastructure for a prompt response to local needs.

LPHU's are expected and often required to provide services and reach people that private and other governmental agencies fail to adequately address. In this context LPHU's are regarded as the residual guarantor for essential services. They are also required by state law to provide services to North Dakota citizens regardless of ability to pay. As a result, services are often rendered without reimbursement either by insurance or client payment. Local health departments operate on relatively small budgets.

Local public health funding sources are generally from local government, state government and federal pass-through funds. The majority of the flexible, non-categorical funding source is from local governments so in order to respond to community needs such as the changes in demography and health status, increased health care costs, the latest health care trends and other funding levels (such as under-funded or unfunded mandates) it requires a continual burden on local tax payers. In addition, there is a barrier to generate additional local tax dollars as health districts' budgets may not exceed the amount that can be raised by a levy of five mills as mandated in state statute. Presently, health districts average a 4.2 mill appropriation.

The 2013 National Association of City and County Health Officials Profile Survey of Local Health Departments, reported financial information for 27 of the 28 North Dakota local public health units that responded to the survey. The reports indicated that there may be even a greater burden on local governments. Population needs have continually increased while budgets especially related to state and federal pass through dollars have decreased. 19% of North Dakota Local Public Health Units reported a decrease in their 2013 budget from the previous year.

LPHU budgets have been further hampered due to limited and categorical funds and have not been able to adequately carry out many of the core activities. Protects against environmental hazards and Prevents injuries are the two core activities most impacted by limited funding. There are no state or federal dollars allocated to local public health specifically for unintentional and intentional injury prevention activities. Many LPHUs use some of the Maternal Child Health Block grant dollars to fund injury prevention activities, but the amount distributed to the smaller health units is less than \$6000. There is also a match requirement for these limited funds. \$110,279 is allocated for environmental health and only \$9,144 of that total is from state dollars. This total funding is allocated for radon, water quality and abandoned auto activities. An additional \$400,000 per biennium of the current state aid allocations is earmarked for the provision of regional environmental health services. This is only \$.57 per capita dedicated to protect local communities against environmental health hazards and an estimated six hours a month of services provided to counties outside of the lead regional health unit jurisdiction. Many of the smaller health units do not have the financial means to contract for additional services which results in many unmet needs and unfulfilled community expectations.

Local communities have also indicated the importance and need for injury prevention efforts. 11 out of the 14 local public health jurisdictions that have completed community health assessments have identified injury or injury related issues as a priority health area to address. Injury is the leading cause of death for people ages 5-49 in North Dakota.

Preventing injuries is extremely cost effective and it is imperative that innovative and effective injury prevention programs work to prevent premature deaths and disability, particularly among vulnerable populations of children, young families and older adults. Local public health has been struggling to continue to provide the many injury

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prevention activities that have been largely subsidized through local dollars. These activities include well baby clinics, newborn home visits, home safety checks, fall prevention, bike safety, car seat safety, farm safety, babysitting clinics, and poison safety. Due to increased public health demands, increased population growth and health needs and limited funding specifically for injury prevention, many LPHUs have reduced and/or eliminated injury prevention programs, especially the car seat safety program. Car seat safety program estimated costs range from \$2000 to \$25,000; except for First District Health Unit which provides an expansive car seat safety program with an estimated cost of \$70,000 per year. An estimated annual average of \$10,000 per health unit is needed to maintain injury prevention programs. In addition to direct delivery of injury prevention services, North Dakota LPHUs play an important role in coordinating broader public health systems' efforts to address the cause of injury and in implementing education and other prevention efforts. LPHUs need **\$280,000 per year** additional state funding to maintain injury prevention strategies and infrastructure.

An effective environmental health infrastructure throughout the state is necessary in order to respond to the much needed customary environmental health services such as abandoned buildings, nuisances, air quality such as mold, water quality and waste and it is imperative to respond to any public health threat. Public Health threats may include food borne outbreaks, water supply contamination or natural disasters such as floods and tornados and other hazards such as train derailments that impact air quality. Only eight of the larger multi-county local public health units employ environmental health practitioners (EHPs). The National Association of City and County Health Official's workforce development survey indicated a recommended ratio of 1 environmental health practitioner FTE per 25,000 population. None of the eight regions have come close to that ratio and therefore, find it very difficult to address the growing population needs in their jurisdiction, much less in the outside LPHU jurisdictions. The costs of providing services throughout a region are increased due to travel and staff time. LPHU's need **\$700,000 per year** additional state aid funds to increase the capacity to provide regional environmental health services and enhance the capability to protect against and to respond to environmental hazards.

This request is not a result of oil impact activity.

Change Group: A	Change Type: C	Change No: 30	Priority: 20
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Rural EMS Grant Assistance

Rural EMS Grant Assistance - \$9,600,000

We are requesting funding in the amount of \$9.6 million per biennium to increase the amount of funding available for the Rural EMS Assistance Fund to a level of \$16 million. The current biennial funding for this grant program is \$6,400,000 per biennium. The grants requested are primarily used to offset operating expenses such as staffing, call remuneration, supplies, and other day to day operational expenses. The shortfall between the requested funding and the funds that are available has been met by only funding a percentage of the individual applications or a percentage of applicants themselves.

Typically, applicants are funded at a level approximately 40% to 90% of their requested funds after disallowed expenses have been subtracted from their application. Not meeting their full requested amount can leave the EMS agency without adequate staff, financial loss, no incentive for additional volunteers, and may affect their ability to fully complete the stated goals and objectives of their application.

Two years ago prior to the legislative session the North Dakota EMS Association asked for \$15,000,000 per biennium in the Governor's budget.

The project time period is ongoing.

There are many factors affecting the delivery of prehospital care; shrinking volunteer workforce, some communities impacted by the oil boom with increasing population and a secondary increase in severity of patients, an increase in the cost of equipment and the generational difference in volunteers make a case for increasing financial commitment to retain the high level of prehospital care that provides protection to our citizens. As the majority of ambulance services in the state are volunteer this plays a large role in sustaining services within the state. Taking into account all of the financial support an ambulance service receives through fee reimbursement, local tax levies, and monies from the state, by far and away the single largest contributor or subsidies an ambulance service receives is the volunteer time spent by the thousands

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of volunteer EMS personnel. We call this the “volunteer subsidy”. It has been estimated that to fully fund ambulance services for the volunteer subsidy it would take approximately \$31,000,000 per year. Volunteers are facing substantial difficulty fulfilling the needs of the EMS agency because in some case a large increase in calls, dwindling volunteer base, business owner less likely to allow volunteers to leave for calls, younger generations volunteering differently than before, competition with high paying jobs that take former volunteers out of the community they live in for longer periods of time, an aging volunteer base, etc. The decline of the system is evidenced by ambulance services closing their doors, fully licensed ambulance services becoming substations or Quick Response Units, the shrinking rosters on ambulance services that once were healthy, longer response times, etc.

Change Group: A	Change Type: C	Change No: 32	Priority: 22
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Diabetes Prevention and Control

Diabetes Prevention and Control - \$139,573 – 1 FTE

The Nutrition and Physical Activity Division is requesting an FTE to assist with work related to diabetes prevention and control. Currently the Diabetes Program is managed with 0.7 FTE. Adding another FTE to the program will dramatically affect the reach of the program.

The goal of the Diabetes Program is to prevent and control diabetes in North Dakota. The new FTE would focus on developing a network and referral system for the Diabetes Self-Management Education (DSME) program. The DSME program is an evidence-based program that reduces the complications for those living with diabetes. North Dakota has 21 DSME programs across the state that have the capacity to provide diabetes education to more North Dakotans. However, there is not a successful referral system in place to connect patients with diabetes into a DSME program.

The position would also work with an epidemiologist to identify counties with a high proportion of diabetes that do not offer a DSME program. They would work with potential sites in the identified areas to work toward implementing a DSME program. This may include developing a “mentoring” program with existing DSME sites to help provide technical assistance to the new potential sites. It may also include modifying the DSME program to be conducted via telemedicine in the areas that do not have the capacity to implement their own program.

There is also a gap in coverage among some insurers. The new FTE would convene stakeholders in Medicaid, Medicare, and the NDPERS to identify if they have gaps in coverage for DSME services and work with these agencies to bridge any gaps.

The position will also work with the Diabetes Program Director to develop a communication plan to increase awareness about the DSME program, diabetes prevention, and control. They will also assist the Diabetes Program Director in managing the Dakota Diabetes Coalition which is a network of healthcare professionals working to prevent and control diabetes in North Dakota.

For 2015-2016 1 FTE and for 2016-2017 1 FTE

- The number of North Dakotans with diagnosed diabetes has increased more than 2.5 times over the past 16 years. It's estimated that 45,232 adults in North Dakota were living with diagnosed diabetes in 2012, with an additional 13,149 adults having undiagnosed diabetes.
- An estimated 184,000 North Dakotans have prediabetes, which, if not addressed, will result in 5 to 10 percent of these cases progressing to diabetes each year.
- Diabetes is expensive. In 2007, diabetes cost North Dakota over \$400 million dollars. If North Dakota follows the national trend, in 2012, diabetes will cost North Dakota \$560 million.
- Diabetes affects the quality of life for those living with diabetes, their families and friends, and their employers.
- Diabetes affects our children. Pediatricians are diagnosing an increasing number of children with type 2 diabetes. Because of the increasing rates of obesity, unhealthy eating habits, and physical inactivity, we may see the first generation that will be less healthy and have a shorter life expectancy than their parents.

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- Diabetes affects both military personnel and the civilian workplace. “Being overweight or obese...is the leading medical reason why applicants fail to qualify for military service,” according to Mission: Readiness/Military Leaders for Kids in a report entitled “Too Fat to Fight.” Diabetes of any type is cause for denying enlistment into military service, and members of the military who develop diabetes during active duty are referred for possible medical discharge or retirement. In the workforce, people diagnosed with type 2 diabetes have more stringent requirements to obtain commercial driver’s licenses (CDL) than those who do not have diabetes.
- Those with type 2 diabetes may be at increased risk for heart disease and stroke, and people with type 2 diabetes have higher rates of absenteeism (number of work days missed due to poor health) and presenteeism (reduced productivity while at work).

This request is not a result of oil impact activity.

Change Group: A	Change Type: C	Change No: 33	Priority: 23
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Enhanced Western ND Water Quality Monitoring

Enhanced Western ND WQ Monitoring - \$729,030

The North Dakota Department of Health, in cooperation with the U.S. Geological Survey’s (USGS) North Dakota Water Science Center and the North Dakota State Water Commission, maintains a network of 81 water quality monitoring sites on rivers and streams in the state. Thirty-two (32) sites are sampled eight times per year and are referred to as “level 1” sites. Twenty-three (23) sites are sampled six times per year and are referred to as “level 2” sites, and 26 sites are sampled four times per year and are referred to as “level 3 sites.” All of these sites are co-located with a USGS gauging station where stream flow is measured.

Fourteen (14) of the 81 sites are in western North Dakota in the Bakken region where there is currently significant oil development. While this current network is adequate for general water quality characterization, it lacks the spatial and temporal resolution necessary to assess potential changes to water quality in the state’s western streams and to Lake Sakakawea. The purpose of this project is to enhance the current ambient river and stream monitoring network by: (1) increasing the sampling frequency of existing water quality monitoring sites; (2) increasing the number of new monitoring sites on rivers and streams where there is currently no monitoring; and (3) enhancing water quality monitoring sites through the addition of “real-time” continuous monitoring for specific conductance and temperature.

The following is a detailed description of the proposed enhanced monitoring network for western North Dakota rivers and streams.

- Convert existing level 3 water quality monitoring sites in western North Dakota to level 2 sites. The purpose of this enhancement is to provide better spatial resolution in sampling which will allow for trends analysis. Level 3 water quality monitoring sites are sampled four times per year, once each in April, June, August and October. Level 2 sites are sampled six times per year, once each in April, May, June, August and October, and once under ice during the winter (January). Level 3 sites which would be converted to level 2 sites include:
 - Long Creek near Noonan
 - Little Muddy Creek near Williston
 - Bear Den Creek near Mandaree
 - East Fork Shell Creek near Parshall
 - Deepwater Creek near Raub
 - Beaver Creek near Trotters
 - Knife River near Manning
 - Heart River near South Heart
 - Green River near New Hradec
- Add additional level 2 water quality monitoring sites on rivers and streams with little or no current water quality monitoring. In addition to water quality monitoring at the sites on these rivers and streams, seasonal flow gauging sites should be added to the sites. Rivers and streams targeted for level 2 monitoring sites include:

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- Shell Creek
- Little Knife River
- White Earth River
- Tobacco Garden Creek
- Timber Creek
- Charbonneau Creek
- Cherry Creek
- Beaver Creek (near Ray)
- Add additional level 3 water quality monitoring sites on rivers and streams with little or no current water quality monitoring. In addition to water quality monitoring at the sites on these rivers and streams, seasonal flow gauging sites should be added to the sites. Rivers and streams targeted for level 3 monitoring sites include:
 - Franks Creek
 - Davis Creek
 - Deep Creek (near Burning Coal Vein)
 - Little Beaver Creek (near Marmarth)
 - Spring Creek (near Bowman)
- Add continuous “real-time” monitoring for specific conductance and temperature at key sentinel monitoring sites including:
 - Little Missouri River at Medora
 - Little Missouri River near Watford City
 - Little Muddy Creek near Williston
 - White Earth River
 - Little Knife River
 - Cherry Creek
 - Bear Den Creek near Mandaree
 - Tobacco Garden Creek
 - Beaver Creek near Trotters
 - Green River near New Hradec

In order to adequately sample to determine water quality trends, a 10-year commitment should be made to the network. Since it is anticipated that oil development will occur in western North Dakota for 20-25 years, it can be expected that monitoring will be needed for 20-25 years or longer.

Funding for this project includes \$134,400 in one-time equipment and installation costs to set up 12 new flow gauging sites (\$11,200 per site) and \$51,000 in one-time equipment and installation costs to set up “real-time” conductivity and temperature monitoring at 10 sites (\$5,100 per site). Once the enhanced network is set up, the first year to operate the network is expected to be \$267,330 and the second year’s cost is \$276,300 per year. **US Geological Survey will incur the expenditures and will be paid by contract from DoH.**

This project is necessary to be able to describe current water quality trends in western North Dakota.

The main purpose of this project is to be able to adequately monitor the water quality of the rivers and streams in western North Dakota to determine if water quality is being impacted.

Change Group: A	Change Type: C	Change No: 34	Priority: 24
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Domestic Violence/Rape Crisis Program

BUDGET CHANGES NARRATIVE**301 ND Department of Health****Bill#: HB1004****Date:** 12/23/2014**Time:** 12:35:59**Domestic Violence/Rape Crisis Program - \$1,500,000**

The North Dakota Department of Health, Division of Injury Prevention and Control is requesting 1.5 million in general funds to grant to the 20 domestic violence/rape crisis centers to provide prevention and intervention services to victims of domestic violence and sexual assault in ND. Funds are currently distributed based on a tier system of services provided by the crisis centers. Tier 1 includes core services such as crisis lines, crisis response/follow-up, criminal justice advocacy, protection order assistance, emergency shelter, awareness and education, and data collection. Tier 2 encompasses stability services such as long term shelter, transitional housing, support group and therapy.

Funds are being requested to support the general operating costs for services offered under Tier 1 and partially under Tier 2. Services provided under Tier 1 and 2 that will be funded with this OAR request include: crisis line, crisis response/follow-up, criminal justice advocacy, protection order assistance, emergency shelter, awareness and education, data collection, long term shelter and transitional housing.

The additional \$1.5 million in state general funds would be distributed as outlined below:

\$1,000,000- add to Tier 1 (\$500,000 each year) to support pay increases (equity) among current staff and new hires and additional operational costs for the core services offered by the 20 domestic violence/rape crisis centers. This funding would be distributed using the current formula.

\$500,000- add to Tier 2 (\$250,000 each year) to support long term shelter and transitional housing. This funding would be available to the programs that operate shelters (Belcourt, Dickinson, Beulah, Williston, Minot, Bismarck, Devils Lake, Grafton, Grand Forks, and New Town) and transitional housing units (Bismarck, Minot, Grand Forks). Fargo does not operate its own shelter or transitional housing but would be eligible for funds as they contract with the YWCA to provide those services.

These funds would be a continuation expense requested in subsequent biennia.

All of the 20 domestic violence/rape crisis centers have reported they are under-funded and short-staffed; a perfect storm of decreased federal funding and explosive population growth has stretched these programs to a breaking point. In 2013, the crisis centers reported they served 913 victims of sexual assault and 4,801 new victims of domestic violence. While the number of victims may not show a substantial increase, crisis centers report that they are spending much more time assisting victims. The increase in population has brought new challenges, including language barriers, human trafficking, and immigration issues to centers that are already strapped for time. The lack of local resources including housing and mental health services adds additional barriers to victims trying to escape the abuse. While smaller staff sizes may have been sufficient in recent years, these programs are now forced to operate in 24-hour crisis mode, leaving victims under-served and staff members exhausted. Due to increased caseloads, advocates can no longer travel to outlying communities to provide services. Rural areas are especially hard hit because those towns often lack the local resources larger cities possess that can provide victims with a safety net. Advocates are providing a form of triage in which phone conversations substitute for face to face advocacy until comprehensive intervention can be provided in a centralized location. It has become increasingly difficult to find, hire and retain advocates to support the growing caseload because of the ability to pay competitive wages.

Additionally, the population growth across the state has created a dramatic strain on the housing infrastructure. In the past the average length of stay for victims in shelter was 30 days but over the last five years this scenario is rare. Most victims are staying in shelter for at least 90 days with some staying as long as 2 years. The lack of affordable housing, high rental prices, long waiting lists and lack of Section 8 housing vouchers has left shelters with no choice but to house victims longer and therefore having to make the difficult decision to turn away other victims because of lack of space.

Statistics show an increase in the number of reported incidents of domestic violence and number of victims served by local crisis centers in the past two years, especially by the centers (Williston, Dickinson, Minot, Stanley, and Beulah) impacted by the oil industry. However, agencies across the state are feeling the impact as influx of people search for housing or jobs in other cities. In Stark County, served by the Domestic Violence and Rape Crisis Center (DVRCC), 80% of client load in 2011 was impacted by oil, meaning either the abuser worked in the oil field or victims in abusive relationships moved to the area to work in the oil industry. The increase in crime and population growth coupled with the rising cost of rent, lack of affordable housing options, understaffed/underpaid crisis centers, and decreasing federal and local sources of funding has led directors to make difficult, often life changing decisions that could have a lasting impact on what services are available for victims in the future.

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Change Group: A	Change Type: C	Change No: 35	Priority: 25
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Regulation of On-Site Sewage Disposal

Regulation of On-Site Sewage Disposal - \$385,243 - 2 FTE

- One Environmental Scientist II (ESII)
- One Environmental Engineer II (EEII)

The ESII will be responsible for:

- Development, implementation and enforcement of a new statewide program for certification and training of septic system installers

The EEII will be responsible for:

- Development of new design standards for alteration, repair, construction and installation of septic systems
- Review/approval of large septic system installations
- Conducting inspections of large septic system installations
- Assistance with technical portions of training for septic system installers

Both the ESII and EEII will serve as a technical resource to local public health units on issues related to on-site sewage disposal.

Under this new program, the department would:

- Develop and implement new statewide design/construction standards for septic systems.
- Review/approve large septic system installations (those serving 25 or more people).
- Inspect large septic system installations.
- Develop and implement a new statewide program for certification and training of septic system installers.
- Serve as technical resource to local public health units (LPHUs) regarding on-site sewage disposal issues.

These are Continuation expenses.

There is currently no statewide program in North Dakota for regulation of on-site sewage disposal. If on-site sewage disposal is regulated, it is typically done by local public health units (LPHUs). These LPHUs have either adopted the general standards within the state plumbing code or adopted similar standards for use within their jurisdictions. There are several issues related to how on-site sewage disposal is presently addressed, including:

- Lack of statewide coverage. Up to 17 counties do not have environmental programs to address on-site sewage disposal.
- Lack of uniform standards. Currently, standards vary between LPHUs that administer on-site sewage disposal programs. These include standards for design and construction of on-site systems and standards for certification and training of on-site system installers.
- Lack of a level playing field across the state. The lack of statewide coverage and uniform standards creates an uneven playing field and confusion for installers. On-site sewage disposal systems have been, and will continue to be, installed in non-covered counties without approval. This increases the chances for failure and adverse environmental and public health impacts.

Change Group: A	Change Type: C	Change No: 36	Priority: 26
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CD Prevention - Healthy Communities

CD Prevention – Healthy Communities - \$850,000

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The Nutrition and Physical Activity Division is requesting funds to establish a Chronic Disease Prevention for Healthy Communities Program to reduce the burden of chronic diseases. The goal will be to assist communities across the state, as they work to change the places and organizations that touch people's lives every day in schools, worksites, health care sites, and other community settings. Funds will support local communities in their efforts to positively impact health as individuals, communities, businesses and as a state.

Prevention measures such as healthy environments and control of risk factors are important steps to save lives, reduce disability and lower healthcare costs. The initiative will invite communities to encourage individuals to maintain a healthy weight; engage in regular exercise, eat well and participate in regular health screenings. Technical assistance and support to the communities will be provided by existing state staff drawing on principles from the social ecological model where interventions for individuals and environments are used. The grants and technical assistance will provide a springboard for community action in the areas of health-related environmental change and support community partners in their efforts to reduce chronic diseases including heart disease, stroke, cancer, diabetes, kidney disease and dementia. The Healthy Communities Program will assist in mobilizing local communities in an effort to create healthier environments. Competing priorities and limited funding result in communities who do not have the resources to implement this kind of an initiative- local support is critical. And the Healthy Communities funding can complement and support other funding (whether local, or state funding like the Cancer grants) who all would like to see successful health initiatives in the local communities.

For communities that are just getting started the grants can help them identify a community-driven strategic planning process, suggest trainings on how to establish a community partnership to address chronic disease (or integrate into an already existing community partnership) so they can develop an action plan aimed at achieving the shared community vision related to chronic disease. For communities that may have already established partnerships the grants are designed to help create an environment that promotes health and supports healthful behaviors in all settings. For those interested in chronic disease prevention through nutrition related activities, examples may include developing nutrition standards for food and beverages for businesses, child care or education facilities or senior centers; increasing access to affordable healthful foods, or helping schools create policies that promote healthful nutrition. Physical Activity strategies might include increasing the amount of daily, quality physical education in schools; or increasing access to physical activity for employees through worksite wellness initiatives; or assisting communities in becoming more walking and bicycling friendly

For those interested in supporting chronic disease self-management, grants could support community-clinical linkages to ensure that people with or at high risk of chronic diseases have access to community resources and support to prevent, delay or manage chronic conditions once they occur. Examples might include increasing availability and accessibility of diabetes, chronic disease self-management education programs, including physical activity programs, to reach at risk populations in community settings, such as worksites, YMCA/YWCAs, schools, senior centers, and other local organizations; or increasing the use of the CDC-approved evidence-based lifestyle change program to prevent or delay onset of type 2 diabetes among people at high risk.

For 2015-2016 \$400,000 and for 2016-2017 \$450,000

Today, Chronic diseases affect almost 50% of Americans and account for 7 of the 10 leading causes of death in the US. Chronic diseases and conditions such as heart disease, stroke, diabetes, cancer, obesity and arthritis cause suffering and limitation to daily function. Preventable health risk factors such as insufficient physical activity and poor nutrition contribute greatly to the development and severity of many chronic diseases. The facts point to North Dakota having a public health crisis when it comes to obesity and chronic illness. Twenty-nine percent of adults are obese (BRFSS 2012, BMI greater than 30) and 13 percent of youth are obese (YRBS 2013). Obesity is the root cause of most chronic illness. Addressing obesity will help control blood pressure, cholesterol and blood sugar/glucose levels which altogether will greatly reduce chronic illness in our population. Like every state in the nation, North Dakota is also experiencing rising rates in overweight and obesity in children and adults.

With a small population and limited fiscal resources, North Dakotans have always recognized the value gained by strong partnerships. North Dakotans hold a deep-seated sense of community, and our people and communities are exceptionally well-connected. Because of these straightforward connections, the possibility of creating real changes is promising. We are suggesting the grants support community environmental approaches that promote health or look at ways to improve community-clinic linkages for self-management.

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Bill#: HB1004

Date: 12/23/2014

Time: 12:35:59

This request is not a result of oil impact activity.

Change Group: A	Change Type: C	Change No: 37	Priority: 27
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State School Nurse Consultant

State School Nurse Consultant - \$142,125 – 1 FTE

The Division of Family Health is requesting a general fund appropriation of \$142,125 to the State Health Department, Community Health Section, Division of Family Health for the purpose of providing statewide school nursing consultation services. State school nurse consultants develop and promote quality standards for school health services. In addition, they serve as a liaison between educators, parents, and the general public regarding the relationship between the health of a student and their capacity to learn. State school nurse consultants serve as a resource expert in school nursing practice and school health programs. This optional request would fund one full time equivalent to serve in the role of state school nurse consultant.

Continuation expense beginning July 1, 2015.

Students establish patterns of healthy behavior during their developmental years and school nurse consultants can serve as a liaison to provide guidance on best practices for improving health. School nursing is a specialized practice of professional nursing that advances the well-being, academic success, and lifelong achievement of students. In addition to serving the student population, school nurses may assist school staff with their health prevention efforts and address current health needs.

State school nurse consultants facilitate the development of standards of care in school nursing and school health programs and serve as a liaison between state departments of health and departments of education along with other school health partners. State school nurse consultants can provide guidance from the state level regarding changes in health policy, nursing, legislation, and legal issues that impact school nursing practice. The recent medication administration legislation highlighted the importance of the need for coordinated state level guidance.

State school nurse consultants facilitate the development of statewide school health policies; examine nursing procedures and quality assurance measures which are needed for ensuring the delivery of safe and effective nursing services in the school setting. Promoting and maintaining optimal health for students is crucial to the success of the local education agency's mission.

The population of ND has increased due to the oil impact and therefore there are more children in the school systems. According to the Department of Public Instruction's Educational Directory, the total enrollment was 112,408 (2013-2014 school year) in comparison with 109,501 (2012-2013 school year). The population of the state is also becoming more diverse which impacts the types of health conditions we see. Health-care systems are overburdened and there is an increased need for access to care. State school nurses consultation is needed to provide coordination, guidance, and resources to facilitate support for those working in underserved areas.

Change Group: A	Change Type: C	Change No: 38	Priority: 28
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Women's Way Services

Women's Way Services - \$500,000

Women's Way, the North Dakota Breast and Cervical Cancer Early Detection Program, is requesting a \$500,000 general fund appropriation to the State Department of Health, Community Health Section, Division of Cancer Prevention and Control, for the purposes of providing breast and cervical cancer services to low income, uninsured and underinsured North Dakota women ages 40 through 64. The funding includes screening fee-per-client-per-year and Diagnostic fee-per-client-per-year to the *Women's Way* Local Coordinating Units (LCUs); outreach, inreach and education to providers, clients and the general public; recruitment, patient navigation and care coordination for hard to reach populations such as American Indian and other ethnic minority populations. There will be no match requirement.

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Initial project period is July 1, 2015 through June 30, 2017. The project will continue into subsequent biennia.

Women's Way provides breast and cervical cancer screening and diagnostic services to North Dakota women who are low income, uninsured or underinsured or can't afford to pay insurance deductible or co-pay. Since 1997, nearly 14,500 women have enrolled and received services provided by the program. These women would not have mammograms or Pap tests otherwise. *Women's Way* detects breast and cervical cancers and pre-cancers and ensures that these conditions are treated. To date, 272 women have been diagnosed with breast cancer and 325 women have been diagnosed with cervical dysplasias or cancer.

There is a general assumption that low income individuals would be covered by either Medicaid Expansion or a Marketplace plan. There are still a number of women who have incomes above the Medicaid eligibility who report they cannot afford the Marketplace health insurance premiums and thus will choose to remain uninsured. It is these women who still need the services of *Women's Way*. Additionally, the Marketplace insurance plans are not without gaps. The preventative services such as a screening mammogram and Pap test are covered. However, if a diagnostic procedure such as a breast ultrasound or a diagnostic mammogram is needed, this is no longer considered preventative and the women must now pay deductibles and co-payments, which she often cannot afford. Providers and women will be looking to the *Women's Way* program to enroll these women and assist with covering these portions of the bill. As of July 6, 2014, nearly 5,000 women have signed up for healthcare through the marketplace and 1,995 women are new participants in Medicaid Expansion. At the beginning of 2014, there were 70,000 non-elderly North Dakotans who were uninsured with 34,300 being women. There is still much work to be done to reach uninsured women and *Women's Way* needs to intensify its efforts to reach these women and facilitate access to cancer screening and required follow-up. These efforts cannot be done without additional monies.

The federal funding from the Centers of Disease Control and Prevention (CDC) may not keep pace with program needs and increased costs. CDC introduced 11 performance indicators as basis for federal performance based funding. Based on these CDC criteria, *Women's Way* instituted a performance based payment system for reimbursement to the local public health agencies serving as LCUs. The LCUs are paid a fee-per-client-per-year after the client has obtained a *Women's Way* service. The LCUs currently receive a screening fee of \$145 per client to provide program essential services with \$140 of the fee being paid by CDC monies. The remaining \$5 per client may be lost without these project funds if federal funding is not available. The \$100 per client for timely diagnostic follow-up paid to the LCUs is dependent upon these project funds.

The LCUs conduct minimal recruitment or public education activities, as the client fees are not enough to cover these program components. This has caused a loss of *Women's Way* program awareness and momentum at the local level. Since the 2011-2013 Biennium, we have seen our enrollment steadily decrease from approximately 3,200 women screened annually to 2,454 women screened during the 13-14 fiscal year. This has also resulted in increased difficulty in finding those "hard to reach" women who need but do not obtain the life-saving breast and cervical cancer services offered by the program. Limited recruited efforts and provision of case management and care coordination is also greatly impacted especially among our American Indian women. During the recent 13-14 fiscal year, *Women's Way* only achieved 76 percent of its screening goal for American Indian women. Women with greater barriers to health care are likely to have lower rates of prevention screenings and more intensive efforts are required to assist these women to overcome barriers to life-saving cancer screenings. Since January 2014, 276 *Women's Way* clients have transitioned to Medicaid Expansion. Yet, our local coordinating units are often called upon to provide the necessary care coordination and patient navigation for these women often without reimbursement.

This request is highly dependent on how the federal government treats the breast and cervical cancer screening grant moving forward. It is also dependent on whether individuals actually get health insurance coverage available to them. A proposal to remove the percentage of the grant that must be spent on direct service, freeing up funding for indirect service (recruiting women, navigation, etc.) has passed one House of Congress. If this provision passes the second House, funding levels stay high enough, and less women want the screenings (caseloads continue at current levels) this optional request may not be needed. A transition plan may be appropriate.

This request is not a result of oil impact activity.

Change Group: A	Change Type: C	Change No: 39	Priority: 6
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Cardiac System of Care

BUDGET CHANGES NARRATIVE**301 ND Department of Health****Bill#: HB1004****Date:** 12/23/2014**Time:** 12:35:59**Cardiac System of Care - \$601,400**

Heart disease is the leading cause of death in the state of North Dakota. The prevention and treatment of this disease with time sensitive treatment needs support by a cardiac system of care. The Cardiac System of Care will provide funding to continue educational efforts in regards to cardiac care to improve the quality of care of patients. This system will also allow the Department to monitor quality of patient care with a database to use towards quality improvement.

Through a focus on time sensitive illness or injury the Division of Emergency Medical Services and Trauma (DEMST), under leadership of the North Dakota Department of Health (NDDoH) and Emergency Preparedness and Response (EPR), has extensive experience in establishing systems of care for Stroke and Trauma. By establishing systems including the entire continuum of health care delivery in North Dakota, we are able through collaboration and coordination to effectively and efficiently affect the quality of care delivered to emergency patients and the public in general throughout our state.

The fundamental premise is to be able to place the emergency patient in a situation to receive definitive care along the continuum in a timely fashion. An example of these systems of care rendered would be the trauma system. Upon receiving significant injuries the trauma system is poised to respond in a manner that gives these patients the best opportunity for survival and minimizing the effects of injury over the long run. Of the 48 hospitals in North Dakota 47 of them have some type of designation specific to trauma injuries. Levels I, II and III are designated by the American College of Surgeons while levels IV and V are designated by the NDDoH. This project is coordinated through the DEMST. While the EMS agency transports an injured patient their guidance is spelled out in rule that they should transport the patient to the closest appropriate hospital for whatever level of definitive care is warranted. If the injuries cannot be fully treated at the level IV or V designated hospital the patient is then transported to one of six level II hospitals where total definitive care is available.

The system which is in place automatically responds to this crisis and the beginning point is when an event occurs and is recognized. The next step is the emergency call to a Public Service Answering Point (PSAP) who will then contact the closest EMS agency and other specialized responders to the scene. The system continues throughout the entire continuum of agencies and hospitals until rehabilitation has finished and the patient can then assume a normal way of life. Each component of the system is put into play so that timely definitive care can be rendered. In trauma the window of opportunity to definitively treat the patient is from the event occurring to the destination where definitive care can be rendered and this window of opportunity is usually referred to as the "Golden Hour".

Because of the generosity of the Helmsley Charitable Trust a number of components specifically for emergency care have been implemented. Four grants in particular have become components of a Cardiac System of Care. Those four grants are:

1. Funding for an eEmergency program which places emergency care for a number of Critical Care Hospitals (CAH) over interactive video to have consultant emergency department physician available 24 hours a day, 7 days a week for emergency care in real time,
2. Simulation in Motion North Dakota (SIM-ND) which has provided for specialized vehicles and training for EMS agencies and hospital within the state to train on high fidelity patient simulators giving the trainees access to many emergency scenarios in a hands-on realistic practice to recognize and gain experience in treating emergency situations,
3. The ability to purchase and train EMS agencies in equipment that not only is a monitor/defibrillator but also a 12 lead EKG with the ability to transmit the EKG to hospitals and physicians to determine if the patient is suffering a ST Elevation Myocardial Infarction (STEMI). This type of myocardial infarction is especially susceptible to treatment with thrombolytic (clot busting) agents. Therefore, thrombolytic therapy could successfully open a coronary artery that has been compromised by a blood clot. The patient can then be transported to one of six Percutaneous Coronary Intervention (PCI) Centers in ND for catheterization of the coronary arteries and a balloon angioplasty, or stents, or bypass surgery can be performed,
4. The placement of automated mechanical CPR devices (known by the product name of Lucas Devices) in all ambulance services and hospitals. These devices have been found to not only perform chest compression but to also free up rescuers to do the many other jobs required during cardiac arrest. Another major component of this grant is to provide funds for the evaluation of the Lucas Devices and also a parallel tract to evaluate a Cardiac System of Care within the state. Very little evaluation of systems have been undertaken but with the addition of evaluators from the Center for Rural Health in Grand Forks and generous funding from the Helmsley Charitable

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Trust to both North and South Dakota an evaluation project has begun. This evaluation process can then be replicated with the other time sensitive diagnosis and other systems of care. This is a major undertaking and this grant when given to the other five states within the Helmsley Charitable Trust's area of influence also calls for additional money for those states to join the evaluation project at the University of North Dakota.

With the above stated four components and all of the other cardiac related work that has been accomplished in the state it is the right time to establish the North Dakota Cardiac System of Care which would collaborate and coordinate the continuum of care elements related to cardiac disease. Again, the continuum includes all of the components regarding cardiac care from the onset of emergency events through rehabilitation and return to a normal way of life.

DEMST already has the staff required for coordination of the components in establishing the Cardiac System of Care. Therefore, we would eliminate the need for adding FTE's for the coordination of this project.

Currently within the Trauma System we have adopted hospital designation criteria and bypass language within our rules for EMS agencies. Consideration of hospital designation and bypass criteria is also appropriate for the Stroke System of Care and that same consideration and bypass language would be appropriate for a Cardiac System of Care. The NDDoH should take the lead in formation of a system of care that would include an overarching Cardiac System of Care Task Force and collaboration and coordination of the resources available in cardiac care and fashioned after the other "Systems of Care" within our state. Since most of the resources utilized in cardiac care in North Dakota already exist it is a matter of coordination of these resources into a system.

Expenditures for this project are ongoing except for \$250,000 consultation from UND to assist Critical Access Hospitals with meeting standards.

The American Heart Association's Mission Lifeline project, which was grant funded by Helmsley Charitable Trust, has come to a close in North Dakota. Without continued support of the Cardiac System of Care, it will be difficult to maintain the improvements created by American Heart Association's Mission Lifeline program done with the use of funds through the Helmsley Charitable Trust. The Division of EMS & Trauma will benefit from an expert advisory panel, the Cardiac System of Care taskforce. The Division will not be able to comply with NDCC chapter 23-47.

Change Group: A	Change Type: C	Change No: 40	Priority: 13
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Salary Equity Package

Salary Equity Package - \$582,688

The North Dakota Department of Health is requesting a salary equity package because of the compression that still exists as a result of instituting the Hay classification system. While improvements have been made in staff salaries, improvements are still needed.

This optional package includes all Sections of the Department of Health except for the technical staff in the Environmental Health (EH) Section. A separate Optional Adjustment Request is being submitted to address equity issues for those staff within EH.

The chart below shows the compression as of July 1, 2014 as compared to July 1, 2012, after implementation of the new Hay System.

Department of Health Employees by Salary Quartile

	<u>New Hay System (July 1st, 2012)</u>		<u>New Hay System (July 1st, 2014)</u>	
<u>1st Quartile</u>	224 employees-	64.9%	114 employees-	55%
<u>2nd Quartile</u>	99 employees -	28.7%	66 employees-	32%
<u>3rd Quartile</u>	21 employees -	6.1%	25 employees-	12%

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4 th Quartile	1	employees -	0.3%	2 employees-	1%
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Before implementation of the Hay Study, 75% (in 1st and 2nd quartiles) of the staff were clustered toward the bottom of the salary range in the previous classification system. However, the Department of Health salary structure did allow for some spreading across the salary range based on longevity and performance. The new system offers almost no spreading in the range as over 93% of all employees were being paid below their market policy point (formerly midpoint) of their range with the implementation of the new Hay System on July 1, 2012. The percentage has improved to 87% over the last two years. Still 55% of all employees are compressed under the 2nd quartile. Over 46% of this percentage (52 out of 114 employees) is made up of employees who have six years or more of experience working in state government. In the Hay system, almost no separation exists between new employees and experienced employees. This creates a significant morale issue for longer termed employees and significantly limits starting salary flexibility in hiring new employees.

The department will be able to match some of the requested general funds with federal for the increases.

The costs are a continuation expense.

An equity increase is required for the department to alleviate the severe compression caused by implementation of the new classification system. This equity increase would improve employee satisfaction rates, reduce turnover rates and also provide a compensation level that is closer to the current level paid in other North Dakota state agencies.

The optional request is not a result of oil impact activity.

Change Group: A	Change Type: D	Change No: 22	Priority: 11
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State Medical Cache

State Medical Cache Increase - \$1,109,000

North Dakota maintains a North Dakota Department of Health State Medical Cache (SMC). This cache contains public health and medical supplies, equipment and pharmaceuticals that are used for emergency response by local and state public health and medical responders. Those responders include public health units, hospitals, clinics, long term care facilities, laboratories, emergency medical services (EMS) providers and others.

One-time funding is requested for additional supplies and durable medical equipment needed for response to large scale disasters and emergencies. These needed supplies and equipment have been identified as a result of actual responses to emergencies, drills and exercises and planning efforts. The needed supplies and equipment are as follows:

- Emergency Response Health and Medical Tents – (\$315,000) – Weather-related emergencies often destroy common infrastructure throughout the community. Medical shelters and pre hospital stabilization sites are needed more than ever to take care of the injured and patients needing to be evacuated from their hospital beds, long term care facilities or vulnerable populations living at home. We outfit these military-style tents with much of the same medical supplies found in a field hospital and EMS settings to temporarily provide lifesaving assessment and treatment in the field until medical transportation can occur to hospitals or other medical facilities. The medical tents are self-contained, have hard plastic floors, are heated, air-conditioned and have electrical generators. Each tent is approximately 36' x 18' and can be connected with other similar tents. Three tents would be purchased.
- Emergency Response Health and Medical Shelter supplies – (\$959,000) – The SMC has sufficient public health and medical supplies and durable medical equipment to care for 1,500 patients for one week. Events such as the 2009, 2010 and 2011 flooding, the natural gas pipeline explosion that affected many of the medical facilities on the eastern side of the state, train derailments and warehouse fires in 2014, we recognized that capacities needed to be increased to care for at least 3,000 people. The needed disposable medical supplies include items such as bandaging, linens, oxygen, laceration trays, catheters, intravenous starter

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sets, defibrillator pads, alcohol swabs, glucose strips, syringes and durable medical equipment such as surge beds, defibrillators, commodes, lifts, stretchers and wheelchairs. Hospitals do not have sufficient quantities of supplies and equipment to meet this need and delivery from the federal government would typically not be available for approximately 72 hours.

- Ten Emergency Response Health and Medical Trailers (53') – (\$76,000) – The North Dakota Department of Health places Emergency Response Health and Medical Trailers in eight North Dakota cities so that these lifesaving supplies and equipment can be rapidly deployed to the scene of emergencies. Acquisition of additional trailers will permit a larger quantity of medical supplies and equipment to be placed in the field for rapid response.
- State Medical Cache Flatbed Trailer – (\$8,000) – A flatbed trailer is needed in order to transport a forklift or skid steer unit from our warehouse to the scene of emergencies in order to unload palletized medical supplies and equipment. This trailer must be available 24 hours a day seven days a week for emergency call.
- Crestron for Department Operations Center – (\$12,000) – The Emergency Preparedness and Response Section operates the Department Operations Center and is able to connect to the health and medical stakeholders and responders in North Dakota through the use of a statewide video conference system. During emergencies, this system is used constantly throughout the event to coordinate responders. A replacement video control system is needed to operate the video system.
- Monitors/Projectors for Department Operations Center – (\$10,000) – Monitors and projectors are needed to replace the existing equipment which is now obsolete and will not function with the new high definition codecs.
- Emergency Preparedness and Response Wheelchair and Stretcher Buses - (\$150,000) – Use of ambulance vehicles during large scale emergencies is inefficient and expensive. Ambulance vehicles are designed to treat and transport only one patient per vehicle. Use of school bus conversion kits allow us to convert standard school busses into stretcher or wheelchair coaches which can typically transport 18 patients per bus. This configuration allows many more patients to be moved in shorter periods of time with fewer responders and less expense. The time needed, however, to convert a school bus at the time of an emergency is excessive. It can take two hours to remove the seats and another two hours to install the conversion kit. We currently have two buses in our fleet that are permanently converted. This funding would be used to acquire 10 additional used school buses which would be permanently converted and placed at various sites across the state for shortened response time.
- Ten Lift Gates for Emergency Response Health and Medical Trailers – (\$75,000) – As semi-trailers filled with requested medical supplies arrive in the field; equipment to unload that trailer is often not readily available. Installing lift gates on the existing emergency health and medical response trailers assures the supplies and equipment can be unloaded in the field without a loading dock or forklifts.
- Refrigerated/Heated Emergency Health and Medical Trailer (53') – (\$90,000) – The Department of Health is required to keep a variety of medications and materials under climate control during deployment to an emergency event. Three 53' trailers are requested to adequately address the capacities needed. These trailers will also be used to increase fatality storage and transportation capabilities across the state.
- Mobile Morgue Trailer – (18 ft., 24 body capacity) – (\$180,000) – These trailers are designed and equipped to process and store the deceased at an emergency mass fatality scene. Currently, the capacity needed in North Dakota is unmet.
- 143kW Mobile Generator – (\$85,000) – Not all health and medical facilities in the state are able to support their operations without electrical power. This unit would become part of the medical cache and would be available when other sources of power are unavailable.
- Human Remains Sealing Station – (\$40,000) – Supplies and equipment to seal 300 bodies following a mass fatality event.

\$891,000 of Equipment has been requested in the base budget using federal funding. If that funding is not received we will need the general funding for these items included in this optional request.

These expenditures are a one-time expense

We have responded to several emergency events in North Dakota including the floods of 2009 and 2011, the H1N1 event of 2009-2010, train derailment at Casselton in 2013, the evacuation of long term care patients from Cavalier to Park River due to flooding in 2013, the Canadian gas plant explosion in 2014 that created heating shortages for health and medical facilities in Eastern North Dakota and many more. At each event we were barely able to provide the amount of care needed for that event. However, if any of these events turned into "worse case scenarios", we would not be able to support the tasks and activities needed.

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Oil activity has increased the level of large scale disaster and emergency threat, but the state has also frequently encountered large scale disasters and emergencies that are unrelated to oil activity.

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LPHU Regional Networks

LPHU Regional Networks - \$367,000

The Office of Local Public Health requests **\$367,000** to provide funding to encourage and allow local public health units to establish and sustain regional networks and to share services within the core public health activities.

Project time period is 2015-2017. The evaluation project and establishing a network in the western part of the state are one-time expenses.

Seventy-five percent of the North Dakota local health units serve single county, city or combined city/county jurisdictions, while the other 25 percent serve multi-county jurisdictions. According to the National Association of County and City Health Officials National Profile of Local Health Departments, 54 percent of North Dakota's local public health units serve a population of less than 10,000. These health units have an average of 3 FTE for all staff, 1.5 FTE being a nurse, and an average budget or expenditures of \$115,000. As a result of the various structures, and workforce expertise and capacity, and because funding sources and amounts differ for local public health units, there is a wide variety in the levels of services they provide and in their capacity to provide comprehensive services. Therefore, it is necessary for local public health units to share services, expertise and capacity to assure North Dakotans can expect equitable public health services regardless of the county they live in.

Local public health units (LPHUs) are the foundation of North Dakota's public health system and the lead organizations providing community based programs and services that assure and protect the health of our citizens. Local public health is operating in an ever changing environment where expectations have grown for expertise and action in new areas such as chronic disease and injury reduction; community organizing; national accreditation with its prerequisites of community health assessments and improvement plans, and strategic plans; clinical prevention; and health information technology without revenue streams to support the work. As local public health administrators and their governing bodies are faced with these growing expectations and challenges, they recognize the need to collaborate and share services, resources and functions for a more effective and efficient local public health delivery system.

The 2009 Legislative Assembly authorized LPHUs to form regional networks through joint powers agreements (JPA) and 2011 Legislative Assembly amended the law and provided \$700,000 to plan and establish regional networks. This funding was awarded to three proposed networks. As a result of the state-appropriated funding and awarded Bush Foundation funding, four regional networks will be established by June 30, 2015. The four networks encompass 24 of the 28 local public health units. Bismarck Burleigh Department of Health is the only LPHU not in a network. First District Health Unit, Upper Missouri District Health Unit, and Southwestern District Health Unit are already multijurisdictional health units, comprised of several counties.

Public health regional networks are an efficient and effective model for delivering public health services because they can increase capacity through collaboration and sharing of services and resources including expertise. There is great potential for local public health networks to provide equitable services and activities throughout the network, that are not typically provided in smaller jurisdictions such, as nutrition, family planning, environmental health, performance management and Quality Improvement. There is even a great potential for networks to provide specialty services beyond the scope that local public health units now provide such as fluoride varnish applications.

The Center for Sharing Public Health Services is an initiative funded by the Robert Wood Johnson Foundation and managed by the Kansas Health Institute. The Center focuses its work on being a resource for cross-jurisdictional sharing (CJS), recognizing there is not a one-size-fits-all approach. The Center strives to develop a collective knowledge of what works and under what circumstances.

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The Center for Sharing Public Health Services identified the following benefits for establishing regional public health services:

- **Consistency and equity:** Regionalizing promotes consistent standard of care and equal level of services
- **Breadth of services:** Regionalization can equip each local health department to deliver the range of services their specific community requires
- **Best of the best:** Regionalization allows communities to access the skills they need, when they need them (even if those skills are not resident within their own health department)
- **Economies of scale:** Regionalization has been shown to offer economies of scale for communities who band together
- **Flexibility:** Local jurisdictions can choose from different models to ensure the best fit for their unique circumstances
- **Access to funding:** Larger districts have greater capacity to apply for grants and are more competitive in grant applications, potentially bringing additional resources to their communities
- **Workforce development:** Sharing resources, greater cooperation and communication, and more standardized training, will yield a stronger and better prepared local public health workforce.

First District Health Unit, Upper Missouri District Health Unit and Southwestern District Health Unit have commonalities in population health needs, operations and services. They also have varying capacity to provide services in different areas. Therefore, even though they are all large multi-county health districts, they would benefit in establishing a network. The network would provide a more formal and coordinated arrangement for them to share services and improve capacity in needed areas. The three health districts did not submit an application for the initial state funding to plan and establish a network because of the other many competing oil impact priorities. They are in a much better position to establish a network now and do not need a large amount of planning time since they have participated in the Vision West assessment process and other oil impact assessments. In addition, two of three health units have completed community health assessments and community health improvement plans. The western health units will need **\$250,000 one-time funding** to establish a network.

All three of the state funded networks have contracted with North Dakota State University and University of North Dakota MPH programs and the Center for Rural Health to facilitate and conduct gap analysis and assessments to identify the appropriate integration and delivery of service structure for the network. It would be very valuable to aggregate and coordinate this information along with operational information to evaluate the effectiveness of the various network models established in North Dakota. **\$117,000 one-time funding** is needed to contract with both NDSU and UND MPH programs for them to collaborate on this evaluation project.

This request is not a result of oil impact activity.

Change Group: A	Change Type: D	Change No: 29	Priority: 19
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Evidence-based Home Visiting Programs

Evidence-based Home Visiting Programs - \$1,500,000

The North Dakota Home Visitation Coalition is requesting a \$1,500,000 general fund appropriation to the state Department of Health, Community Health Section, Division of Family Health for the purpose of expanding and enhancing evidence based home visiting programs/services through a community match. An evaluation component will examine programs ability to “move the needle” on Maternal and Child Health (MCH) priority areas.

July 1, 2015 to June 30, 2017. This is a request for one-time biennium funding.

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Evidence based home visiting programs/services have proven effective at addressing a variety of MCH issues such as reduction of injury, increase in prenatal care, increase in immunization rates, and reduction in prenatal tobacco use. Evidence-based programs work within the established early care structure to provide consistent guidance to pregnant women and families with young children. Programs target families that may be at risk to experience poor pregnancy outcomes and/or early childhood health outcomes. In addition, programs have the advantage of working directly in the home during the most formative periods of development to establish strong professional to client relationships.

Currently, ND has four nationally recognized models operating in ten sites serving approximately 600 pregnant women and infants. Existing programs are serving high risk areas of the state including the Turtle Mountain and Spirit Lake reservations; however these services are not available in many other areas of the state with significant need. Existing programs are at capacity and have waiting lists.

Increased population of at risk families has impacted overall availability of home visiting services. Existing public health resources for at-risk pregnant women and infants is at capacity. Preference for this project would be given to communities most affected by oil/energy impacts.

Change Group: A	Change Type: D	Change No: 31	Priority: 21
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Reducing Infant Mortality

Reducing Infant Mortality - \$475,000

The ND Sudden Infant Death Syndrome (SIDS) Program is requesting a \$475,000 general fund appropriation to the State Department of Health, Community Health Section, Division of Family Health, for the purpose of reducing infant mortality by providing cribs to families in the state through the Cribs for Kids (CFK) program, updating educational materials to reflect current national safe sleep recommendations and developing a media campaign to raise safe sleep and Sudden Infant Death Syndrome/ Sudden Unexpected Infant Death (SIDS/SUID) awareness.

July 1, 2015 to June 30, 2017.

This is a request for one-time biennium funding.

SIDS/SUID is the number cause of infant death to babies one month to one year of age in ND. Data from the Division of Vital Records indicates there have been 40 SIDS/ SUID deaths in ND from 2009 through 2013, with 15 of those deaths occurring in the American Indian population. By creating awareness of this problem and providing families opportunities to provide a safe sleep environment to their children, we can reduce these numbers in ND.

In July of 2014, ND joined the Infant Mortality Collaborative Improvement and Innovation Network (COIIN) Initiative; a Maternal and Child Health Bureau (MCHB) initiative in which all states and jurisdictions are participating. Due to the fact that SIDS/SUID is the number one cause of infant death in ND for babies one month to one year of age, the COIIN Core Team has chosen safe sleep as their key strategy of focus, with a specific emphasis on the American Indian population.

ND Century Code 23-01-05 states that ND will “establish a program to provide information to the surviving family of a child whose cause of death is suspected to have been the sudden infant death syndrome.” As a program strategy to reduce sleep related deaths in infants, ND became a Cribs for Kids (CFK) partner site in 2010. The CFK program supports the “Safe to Sleep” national campaign to reduce the risk of SIDS/SUID, which is an expansion on the previous “Back to Sleep” campaign. Since the start of the “Back to Sleep” campaign in 1994, SIDS rates in the nation have fallen by over 50 percent; hence we know these strategies are effective. Since 2010, over 1,100 crib kits have been distributed to partner sites throughout the state. These crib kits include a pack-n-play crib, tight-fitting crib sheet, Halo SleepSack, and pacifier. Verbal reports from the partner sites indicate that the crib kits have been a huge success. Some programs report a waiting list for the crib kits, especially in the American Indian population sites.

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Funding to support these program initiatives, mandates and strategies to reduce infant mortality are very limited. Funding was provided for the CoIIN Core Team to attend a Learning Summit in July 2014; however, no additional funding support is being provided by MCHB for implementation of this initiative. MCH grant funds support a .5 FTE to manage the SIDS Program; however, funding to purchase additional crib kits and to develop a statewide media campaign to educate the public and health care providers on safe sleep practices is not available through these funds. With healthcare costs rising, prevention needs to be a priority. By educating families on the risks of SIDS/SUID and by providing them with a safe sleep environment for their child, health care costs can be reduced.

ND has seen an increase in population due to growing oil/energy development. With this influx of people, there has been an increased need for housing. Limited housing opportunities may result in not having an appropriate safe sleep environment for infants. At this time, there is one new partner site located in Williston and no current sites in Dickinson. A portion of this funding would provide cribs to start new sites or sustain new sites in these areas to help with the oil/energy impact on families who may be struggling to find a safe place for their baby to sleep.

Change Group: A	Change Type: D	Change No: 100	Priority: 1
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Oil Impact

Division of Air Quality

Staff increases, as well as the addition of an air monitoring station, are needed to address workload increases associated with oilfield development in western North Dakota.

- Two (2) FTEs in the Air Permitting and Compliance Program
- One (1) FTE in the Radiation Control Program
- One (1) FTE in the Air Monitoring Program
- Add an air monitoring station to be located in western North Dakota.

This is a continuation expense.

Adding staff allows the division to address the workload it is experiencing in issuing permits for air quality operating permits and licensing for waste haulers who need radiation certification registrations. In addition, the division will have more staff to perform inspections and investigations to ensure compliance. The number of air quality industrial construction permits issued has increased from a historical average of approximately 20 per year to more than 80 per year estimated in 2014. Well permit registrations have risen from approximately 3,000 in 2009 to approximately 7,400 in 2013 and are expected to increase with continued oilfield development. The project also includes the addition of an air monitoring station in western North Dakota to continually monitor and track air quality in the Bakken region.

This is a result of oil impact activity.

Division of Laboratory Services

Provide laboratory response to environmental and public health issues that occur in and as a result of the oilfield activity in North Dakota.

- One (1) Chemist II
- Request general funds for lab instruments. These instruments are also included in the base budget in case revenue should become available. However, since this request is related to the oil impact, it is being included as part of this optional package in order to secure funding.

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- Request general funds for repairs - instrument service contracts.

This is a continuation expense for FTE and repairs; one-time expense for instruments of \$600,000

- Chemist II for lab QA/QC review, certification of out-of-state labs and testing oilfield-related samples
- Instruments needed for maintaining lab testing capacity and capability
 - Refrigerator/freezer
 - PC replacement for GC/MS instrument
 - Software upgrade for GC/MS instrument
 - Software assurance WIN SVR STD SNGL MVL - Provide current licensing for the windows server for the laboratory information management system (LIMS).
 - Inductively coupled plasma atomic emission spectrophotometer (ICP)
 - Inductively coupled plasma mass spectrophotometer (ICP/MS) - Replace 11-year old instrument that is failing.
 - Ion chromatogram autosampler - Replace existing one with a new model with more features and user-friendly applications.
 - Organic evaporator - Replace existing evaporator that is 22 years old and failing.
 - LC/MS/MS - New technology that can be used for public health and environmental testing. Work is being performed between the U.S. Environmental Protection Agency (EPA) and vendors of LC/MS/MS systems on building library databases of analytes related to hydraulic fracturing, and the LC/MS/MS will play a major role in future analyses of these compounds.
- Instrument service contracts needed to maintain functional operating instruments to meet the testing needs
 - Agilent - Supports all of the hardware and software of the GCs and GC/MS instruments for organic testing.
 - Perkin Elmer - This contract supports all of the hardware and software for the instruments that test for metals.
 - Thermo Electron (FT-IR) - Instrument used to help identify unknown substances or samples.
 - Thermo Fisher (Atlas chromatography) - Provides technical support, patches and problem resolution for Atlas.
 - Thermo Dionex - Instruments used to test for anions such as chlorides and sulfates.
 - Metrohm - Supports instrument that is used strictly for testing bromide and other anions in oilfield samples.
 - Teledyne Tekmar - Instruments used to test for gasoline range organics and other volatile organic compounds.
 - Star Lims - LIMS used by the microbiology lab to receive, track, result, record and secure test result data and protected health information.
 - Getinge - Autoclave sterilizer used for making media, reagents and sterilizing biohazard waste for common disposal.
 - Abbott - Architect i1000 analyzer which is used to test for HIV and Hepatitis A, B and C infections, all of which have seen testing increases in western North Dakota.
 - Cepheid - SmartCycler DNA analyzers. Instrument tests for many agents such as influenza, norovirus, West Nile virus and Bordetella pertussis (whooping cough).
 - MiSeq - Illumina DNA sequencer used for molecular identification of bacteria and viruses, including Mycobacteria species. This instrument also enhances current pulseNet foodborne agent strain-matching capabilities to determine sources of foodborne outbreak disease.
 - Courier - Service used to transport clinical and environmental samples to the Division of Laboratory Services daily. Rapid sample delivery is critical for sample quality and timeliness of test results in response to potential outbreak testing, critical care issues or environmental incidents.

This request is a result of oil impact activity.

- The increase in sample load for the chemistry lab has increased the volume of QA/QC review and oversight as well. In addition, there has been an increased demand by out-of-state laboratories seeking North Dakota lab certification that would allow them to provide environmental testing data to the department on oilfield-related projects. This has contributed to increases in oversight and review of associated documents and forms from these labs, which involve confirming that said lab meets all state rules as well as the promulgated methods set forth in EPA's Safe Drinking Water Act, Clean Water Act, and Resource Conservation

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- and Recovery Act. Lab certification requests and applications directly related to the oilfield included three in-state requests and six out-of-state requests in the last 12 months alone. Each in-state request takes at least five working days to process and, if needed, an on-site visit of five working days follow-up.
- The increase in sample load, coupled with the need for rapid response in many cases, validates the need to maintain the instruments in working order with minimum down time. There has been an approximate increase of 49 percent in oilfield response samples from 241 samples analyzed in fiscal year 2012 to 360 samples analyzed in fiscal year 2013. This is supported by purchasing service/maintenance agreements from the instrument manufacturers that guarantee the instruments will be serviced on a priority timeline. (Federal and special funds also will be used to help fund these service agreements.)
 - New instruments are needed to maintain the testing capacity and capability of the lab. Some of the existing lab instruments are ending their lifecycle and can no longer be repaired or maintained, thus creating a need to be replaced. (Federal and special funds also will be used to help fund these instruments.)

Division of Municipal Facilities

This project is to provide additional staffing to better keep pace with the significant and ongoing increased workload associated with oilfield activities.

- One (1) Data Processing Coordinator II (DPCII)
- Two (2) Environmental Engineer IIs (EEII)

This is a continuation expense.

The division continues to experience a heavy and increasing workload. This is due to the increased number of new public water systems; Safe Drinking Water Act (SDWA) violations; data requests and complaints; non-community public water systems requiring inspections; non-certified or under-certified water distribution system operators; plans and specifications approvals for water/wastewater system infrastructure projects; and the number of current and potential State Revolving Loan Fund (SRLF) projects.

This increased workload is compounded by implementation of new and revised SDWA and SRLF Program requirements; heightened community interest in using the SRLF programs for financial assistance to address infrastructure needs; turn-back of historically performed work by local public health units; and reduced federal funding which impacts the division's ability to maintain state delegation for its programs. These challenges are not short-term but long-term. The division needs additional staffing to better keep up with and address this increased workload.

The total number of public water systems (PWS) has increased from 514 in 2010 to an estimated 687 in 2014. In 2010, 156 of these systems were in oil-impacted counties. The 2014 estimates project there will be approximately 332 systems in oil-impacted counties. In 2010, the total number of SDWA violations were 203, with 73 of the violations in oil-impacted counties. The 2014 estimates are 427 total SDWA violations, with 332 of the violations in oil-impacted counties. Since 2010, the number of water and wastewater projects submitted for review/approval have significantly increased, largely due to projects in the oilfield. In 2010, the number of projects submitted totaled 179. The 2014 estimates are for 460 projects.

This request is a direct result of oilfield activities. Over the last three years, the division has experienced a significant increase in the number of new public water systems; SDWA violations; non-community public water systems requiring inspections; non-certified or under-certified water distribution system operators; plans and specifications approvals for water/wastewater system infrastructure projects; and the number of current and potential SRLF projects.

Division of Waste Management

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Four (4) additional FTEs are needed for the Solid Waste and Large Volume Landfill programs. One would be dedicated halftime to spill response team work; others would respond to illegal dumping/spill incidents as needed.

This expense will continue until oilfield activity and work load falls back to pre-2010 work levels.

Proper and complete oversight of solid waste management activities is critical to protecting human health and the environment in North Dakota.

Since 2010, industrial/oilfield special waste facilities have increased from four to 10. There are indications that number may double in the next three to six years. The volume of oilfield special waste disposed in these landfills has increased from less than 10,000 tons in 2001 to more than 1,780,000 tons in 2013. That volume will also continue to increase. TENORM waste is a completely new issue that the department has never had to deal with prior to 2010, and now the workload of responding to rejected waste loads takes considerable staff time. New TENORM rules will increase the workload further as we track disposal of the TENORM waste from “cradle to grave.” There also are many other smaller issues that, combined, consume considerable staff time including responding to citizen complaints, illegal dumping, road dust, etc.

Division of Water Quality

To address the increased workload across the programs within the Division of Water Quality, an additional three (3) FTEs are needed.

- ESII - Groundwater Program
- ESII - Spill Investigation Team
- Env. Science Admin. I - Spill Investigation Team Leader

The project will continue until the demand for permits and spill response due to oilfield activity has decreased.

The inventory of Class V wells has increased from 548 to 792 since 2010, and the number of spills has also increased from 729 to an estimated 2858 for 2014. The demand for NPDES permits continues to increase, particularly for construction stormwater. Current staff cannot keep up with entering the new application information into a data management system.

The oil activity has caused an increase in the number of spills requiring response and follow-up, as well as an increase in the number of facilities requiring various types of permits.

Information Technology

The Environmental Health Section (EHS) has completed an internal review and assessment of the use of information technology (IT) within the section. With the increased workload driven by the oil-related activity within the state, the EHS developed a two-phase plan to enhance the use of IT to help the section work better. This project will:

- Update the information technology tools and data systems within the EHS.
- Bring systems and processes up to current technology standards.

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- Provide improved functionality for supporting the business needs of the various program areas. This includes updating several program database systems to provide:
 - Electronic tracking
 - Electronic documents and electronic records
 - Remote access to records
 - The capability for regulated entities to submit reports and information in electronic format rather than using paper

This is a continuation expense. The section is requesting \$1,222,248 in general funds for IT work related to oil impacts for the 2015-2017 biennium.

In the development of the IT Plan, the EHS identified a total Phase 1 cost of \$3,400,819 for the next biennium. Of this amount, \$1,222,248 is being requested by the section for IT work related to oil impacts for the 2015-2017 biennium. The EHS would need to look to federal and special funds, if possible and available, for funding the non-oil impact goals/objects in Phase I of this plan. The second phase would cost an additional \$2,200,000 projected for the 2017-2019 biennium. After the two-phase plan is implemented, ongoing expenses are estimated to be about \$600,000 for subsequent biennia. The EHS would need to look to federal and special funds, if possible and available, for funding the non-oil impact goals/objects in Phase I of this plan.

Communication and the way the public is accustomed to doing business are increasingly moving to electronic forms. If the section does not improve its ability to use electronic communication tools, it is limiting its interaction with and service to customers. In addition, the EHS filing and records system must be able to accommodate electronic documents and records, as some records do not easily convert to paper. Because section files are primarily paper, the filing system is becoming fragmented as more information is being received in electronic format and either cannot be, or is not being, converted to paper records.

With the increased workload from the energy industry in the state, staff needs to be more efficient and productive. Information technology enables staff to work more efficiently by:

- Providing better access to information and records.
- Having the ability to complete and save records in the field so they are readily accessible, rather than having to wait and retype documents once they return to the office.
- Providing electronic information to regulated entities, rather than collecting and sending hard copies of the information.

A portion of the request is the result of oil impact activity. It is estimated that \$1,222,248 (requested funding for Phase 1 of this project) can be attributed to oil activity. Some of the impacts are directly related to oil activity (e.g., the tracking system for the oilfield response team). Others are more indirect, for example, the impacts to the State Revolving Fund Program which now needs a system to track the large number of projects throughout the state and their status. While not all projects are in oil country, the increased workload related to the oil activity has highlighted the need for a better tracking system.

Emergency and Oilfield Activity Spill Response - Salary Add-On

This project will provide a salary add-on for Environmental Health Section (EHS) employees who work emergency and spill response activities on a full-time and part-time basis.

The EHS proposes a salary add-on of \$300/month for full-time oilfield staff. This add-on would be provided on a monthly basis at \$300/month (x 24 months for the biennium) for a subtotal of \$7,200 per FTE in salary. Fringe would be 21 percent of \$300/month or \$63/month x 24 months = \$1,512 per FTE. The projected emergency and spill response FTEs for the 2015-2017 biennium (if new FTEs are approved in this optional request) would be eight (8). Therefore, \$7,200 x 8 = \$57,600 (salary add-on) + \$1,512 x 8 = \$12,096 (for fringe), totaling \$69,696 in this add-on for full-time FTEs.

Full-Time Salary \$ 57,600

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Total Full-Time \$ 69,696

The EHS also has six FTEs who assist with oilfield work on a part-time basis (i.e., one week per month), and it continues to seek this assistance from current staff. The part-time response employees would also be asked to respond on an emergency basis periodically – not as frequently as the full-time staff, but to be on call and able to respond as needed in addition to the one week every two months. It is projected that the EHS may have eight such FTEs for the 2015-2017 biennium. For these FTEs, the EHS proposes to provide a salary add-on of \$150/month (x 24 months for the biennium) for a subtotal of \$3,600/FTE x 8 = \$28,800. Fringe would be \$31.50/month (x 24 months for the biennium) = \$756/FTE x 8 = \$6,048. This would result in a total of \$34,848 for the biennium for salary add-on for FTEs who assist with oilfield work on a part-time basis.

Part-Time Salary \$ 28,800

Part-Time Fringe \$ 6,048

Total Part-Time \$ 34,848

The total for this optional package is **\$104,544**, including \$86,400 for salary add-on and \$18,144 for fringe.

This is a continuation expense for this salary add-on is needed in order to recruit and retain emergency response and oilfield FTEs.

Salary add-on is needed in order to recruit and retain quality staff. In the past several years, the EHS has hired and trained new staff for oilfield work, and few of them have remained due to the long days and repeated weekend work, along with extensive travel. The department has trained new staff, only to have them recruited by industry and other entities with higher salary and often times, less travel and work.

This request is the result of oil impact activity. The increased oilfield impact work has significantly challenged current staff members. To the state's credit, these employees are dedicated and willing to put in the necessary work when there is an emergency and/or spill. However, often times the EHS has hired and trained new staff only to have them recruited by industry offering higher salary and/or better work schedules.

Salary Equity

The Environmental Health Section (EHS) has been experiencing technical staff turnover in excess of 20 percent in several areas, resulting in adverse impacts in meeting our mission goals of public and environmental health protection.

To address the issue of staff turnover and loss of technical expertise, the EHS proposes to establish a culture of technical competency and to recruit and retain employees by:

- Increasing salaries of technical positions by an average of 15 percent to address the inequity with the private sector. Although this will not be comparable to private sector salaries, it will help to close the gap.
- Establish a policy where employees will be elevated from a II to III classification faster based upon performance and job duties.
- Provide recruitment and employee retention bonuses based upon years of service and performance.

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The 2015-2017 Salary Request for the EHS technical positions is estimated to be \$15,813,528. The section proposes that 15 percent of this amount or \$2,372,075 is needed for salary equity, and \$498,133 is needed for fringe (21 percent of salary) for a total of \$2,870,208 to address salary equity issues.

This is a continuation expense for this salary equity is needed in order to recruit and retain qualified EHS employees.

Funding is needed to continue to meet the department goal of preserving and improving the quality of the state's environment. Historically, the EHS has been viewed as the training ground for private industry and has had to address the challenge of routinely replacing a limited amount of critical staff to meet its regulatory requirements. However, recent trends brought on by the exponential oilfield, municipal and industrial development have increased the turnover rates with no anticipated relief. Reasons for the higher employee turnover and resulting impacts include:

- Continued oilfield, municipal and industrial development which has resulted in the need for environmental professionals in the private sector, creating job opportunities for trained staff like those in the EHS. Many of these jobs pay considerably more, in some cases 40 to 100 percent more, than current pay for employees in the EHS.
- Established private companies are experiencing retirements that are creating job opportunities throughout the industry. Trained employees from the EHS are seeking to fill these positions due to significantly higher pay.
- Potential for advancement and ultimately higher pay in the private sector has resulted in EHS employees with five to 10 years experience leaving the department.

The increased oilfield impact work has significantly challenged current staff members. To the state's credit, these employees are dedicated and willing to put in the necessary work to meet the increased workload. However, often times the EHS has hired and trained new staff only to have them recruited by industry offering higher salaries and/or better work schedules. A continual revolving door of recruiting, hiring and training new employees is adding to current staff workloads along with the increased oilfield workload.

Spill Cleanup Fund When A Responsible Party Can't Be Determined

The Department currently has a fund that assists in the response and cleanup for environmental incidents/spills that occur where the Department is not able to determine a responsible party. We would like to have this fund at about \$400,000 for the biennium. The Department has obligated \$ 25,000 to a cleanup contractor during the current biennium. We also provided assistance with cattle frozen in a river. We anticipate perhaps \$25,000 more to be spent in the second year of the biennium out of this fund (projected according to what has occurred this first year). We request \$50,000 for this fund to be able to secure/procure needed cleanup for those spills/incidents where no responsible party can be found.

This is a continuation expenses are needed in order to keep this fund at about \$400,000 available for necessary response and cleanup.

The Department currently has a fund that assists in the response and cleanup for environmental incidents/spills that occur where the Department is not able to determine a responsible party. We would like to have this fund be about \$400,000 for the biennium. The Department has obligated \$ 25,000 during the current biennium. We anticipate perhaps \$25,000 more to be spent in the second year of the biennium. We request \$50,000 for this fund.

The Department has utilized current funds to address oil impact related activities this biennium.

Legal Assistance

The EHS legal costs are projected to increase with the oilfield activity occurring. The Attorney General's Office provides the Department with excellent legal services and representation. With the increased workload associated with oil activity, there has been consideration of finding additional resources in order for this assistance to continue on a timely and thorough basis to the Department.

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This is a continuation expense for this is needed in order that the EHS continue to develop adequate laws and rules and is able to continue to enforce our laws and rules. Oilfield enforcement activities are becoming more complex and time-intensive.

The EHS employees are experiencing greatly increased workloads, oftentimes with quick turnaround times for work response. Timely legal assistance is needed by the EHS in order to respond to increased activities and challenges. Legal assistance has always been provided in a timely and thorough manner. However, this area also, is starting to see the need for increased resources in order to continue to provide this service.

The increased oilfield impact work has significantly challenged current staff members. We continue to need timely and thorough legal assistance in order to continue to meet our workload challenges.

Change Group: A	Change Type: E	Change No: 2	Priority:
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Remove One-Time Funding

Administrative Support

Funding for Regional Public Health Networks has been removed from the budget as it was a one-time appropriation.

Medical Services

Funding for contracting for autopsies has been removed from the budget as it was a one-time appropriation.

Health Resources

Funding for Food and Lodging Licensing Management System has been removed from the budget as it was a one-time appropriation.

Community Health

Family violence contingency funding has been removed from the budget as it was a one-time appropriation.

Environmental Health-

Funding for EPA legal fees has been removed from the budget as it was a one-time appropriation.

Change Group: A	Change Type: E	Change No: 9	Priority:
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Remove One-Time ARRA Funding

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Remove all ARRA funding from the base budget.

Change Group: A	Change Type: F	Change No: 3	Priority:
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Remove 2013-15 Bond Payments

Remove current biennium bond payments

Change Group: A	Change Type: F	Change No: 4	Priority:
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Remove 2013-15 Extraordinary Repairs

Remove current biennium extraordinary repairs

Change Group: A	Change Type: F	Change No: 5	Priority:
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Remove 2013-15 Equipment Greater Than \$5000

Remove current biennium equipment greater than \$5000

Change Group: R	Change Type: A	Change No: 1	Priority:
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Environmental Oil Impacts

Provides \$8,910,603 and 14.00 FTE to address the environmental oil impacts in western North Dakota.

Change Group: R	Change Type: A	Change No: 2	Priority:
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Immunizations

Provides \$755,953 to maintain and increase childhood immunization rates. Funding includes \$179,100 is for a school immunization module that provides an interface between the NDIIS and SLDS; \$576,853 for universal vaccines due to increased costs of vaccines and new immunization recommendations.

Change Group: R	Change Type: A	Change No: 3	Priority:
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Infectious Disease

Provides \$500,000 for a catastrophic fund for infectious disease outbreaks.

Change Group: R	Change Type: A	Change No: 4	Priority:
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Forensic Examiner Infrastructure

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Provides \$224,000 for forensic examiner infrastructure. Funding includes \$160,000 to restore the autopsy contract with UND; \$44,000 one-time funding for digital x-ray equipment; and \$20,000 one-time funding to modify the vital records system to allow for electronic review of death records.

Change Group: R	Change Type: A	Change No: 5	Priority:
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Food and Lodging

Provides \$792,016 and 5.00 FTE for Food and Lodging inspectors. Due to increased number of food and lodging establishments and the results of an audit recommendation, additional and more frequent inspections are required.

Change Group: R	Change Type: A	Change No: 6	Priority:
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Suicide Prevention

Provides \$500,000 to increase suicide prevention with an emphasis on youth and underserved populations.

Change Group: R	Change Type: A	Change No: 7	Priority:
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Loan Repayment

Provides \$712,500 for the loan repayment program. Expands the program to include Behavioral Health professionals with \$495,000 for psychologists, social workers, addiction counselors, and other behavioral health workers. Also provides \$217,500 for additional slots for 1 dentist, 1 midlevel practitioner and 2 physicians.

Change Group: R	Change Type: A	Change No: 8	Priority:
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Salary Equity

Provides \$_____ \$582,688??? for salary equity based on 56% of the DoH employees are in the first quartile and overall agency compa ratio of .88 and 13.2 average years of service.

Change Group: R	Change Type: A	Change No: 9	Priority:
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Local Public Health

Provides \$1.0m increased funding to local public health units for a total of \$5.0m.

Change Group: R	Change Type: A	Change No: 10	Priority:
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Rural EMS Grants

Provides a \$1.6m increase to \$8.0m for Rural EMS grants.

Change Group: R	Change Type: A	Change No: 11	Priority:
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Domestic Violence and Rape Crisis

BUDGET CHANGES NARRATIVE

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Provides \$500,000 for domestic violence and rape crisis.

Change Group: R	Change Type: A	Change No: 12	Priority:
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Women's Way

Provides \$500,000 from the general fund for Women's Way, previously funded with community health trust fund dollars.

Change Group: R	Change Type: A	Change No: 13	Priority:
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Surge Bill

Change Group: R	Change Type: A	Change No: 100	Priority:
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Executive Compensation Package Adjustment

This budget change provides funding for recommended 2015-17 compensation adjustments.

Change Group: R	Change Type: B	Change No: 1	Priority:
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Medical Cache

Provides \$989,000 for medical cache supplies including \$30,000 for 2 used school buses that will be converted to transport wheelchairs and stretchers.